A STUDY OF THE SERVICE NEEDS OF PREGNANT ADDICTED WOMEN IN MANITOBA

Caroline L. Tait

June 2000

*A policy research project funded by Manitoba Health
and conducted in cooperation with the
Prairie Women's Health Centre of Excellence*

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CONTENTS

Acknowledgments ... i
Executive Summary and Key Recommendations ii
PART 1: INTRODUCTION ... 1
A. BACKGROUND ... 1

B. PROJECT COMMITTEES

1. PWHCE Project Working Group ... 1
2. Project Advisory Committee ... 2
C. METHODOLOGY ... 2
1. Determinants of Health ... 1
2. Research Strategies ... 4
3. Sample Population ... 7
4. Methodological Limitations ... 8
D. STEPPING AWAY FROM THE CONCEPT OF ADDICTION ... 9
PART 2: THE RANGE OF PROGRAMS AND SERVICES AVAILABLE TO PREGNANT WOMEN WITH SUBSTANCE MISUSE PROBLEMS ... 10
A. PREVENTION PROGRAMS ... 10
1. Defining Risk ... 10
2. Prevention for School-aged Children and Adolescents ... 13
a. Health Education ... 13
b. Birth Control Education ... 14
c. "Baby Think It Over" ... 15
3. Prevention for Pregnant Women and Women of Childbearing Age ... 16
a. Public Health Messages ... 16
b. Mentor Programs ... 18
c. Community Wellness ... 20
B. SECONDARY PREVENTION AND EARLY INTERVENTION PROGRAMS ... 22
1. Programs for Pregnant Women and Women of Childbearing Age ... 22
a. Pregnancy Programs ... 22
b. Community Services for Women ... 23
c. Place *versus* Program ... 25
d. Health Care Providers ... 26
e. Child and Family Services ... 27
f. Poverty and Service Delivery ... 29
C. DETOXIFICATION AND TREATMENT PROGRAMS ... 29
1. Detoxification and Outpatient Withdrawal Units ... 30
2. Outpatient and Day Treatment ... 31
3. Residential Treatment ... 32
4. Aftercare ... 33
5. Self-help and Support Groups ... 33
PART 3: THE WOMEN'S EXPERIENCES 35
A. PROFILE OF THE WOMEN INTERVIEWED 35
1. Socio-economic Status ... 36
a. Employment ... 36
b. Income ... 37
c. The Impact of Poverty ... 37
2. Age Cohorts ... 39
3. Problems of Substance Misuse ... 40
a. Participants' Substance Use ... 40
b. Substances Used ... 40
c. Familial Substance Addiction ... 41
d. Foster Care ... 42
4. Other Factors ... 44
a. Mental Health Problems ... 44
b. Sexual Assault and Abuse ... 45
c. Physical Violence ... 45
d. Extreme Physical, Emotional, and Sexual Abuse and Neglect ... 46
5. The Experience of Pregnancy ... 46
a. Abortion ... 47
b. Birth Control ... 47
c. Substance Use During Pregnancy ... 48
6. The Women's Children ... 52
a. Children's Health Problems Related to Mother's Substance Use ... 53
b. Apprehension of Children ... 53
B. ADDICTION TREATMENT ... 56
1. Reasons Why Women Enter Addiction Treatment ... 56
a. Force or Coercion ... 57
b. Freely Choosing Treatment ... 59
2. Barriers to Accessing Addiction Treatment ... 61
a. Psychological Barriers ... 61
b. Barriers Related to Women's Children . 63
c. Barriers Related to Social Networks ... 70
d. Barriers Related to Socio-geographic Factors ... 71
e. Stigma ... 72
f. Treatment Program Barriers ... 73

3. The Treatment Experience 76
  a. Positive Aspects of Treatment Identified by Participants 77
  b. Negative Aspects of Treatment Identified by Participants 78
  c. Program Environments and Attitudes . 79
  d. Duration of Treatment Program 81
  e. Separation from Children 82
  f. Treatment Location 83
  g. Other Clients 83
  h. Male Clients and staff 84
  i. Privacy 86
  j. Treatment Philosophy 86
4. Dropping Out of Treatment 87
  a. Reasons for Leaving Treatment 87
  b. Social Environments 99
  c. Treatment Programs 88
5. Maintaining Recovery 89
  a. Reasons for Relapse 89
  b. Aftercare Services 90
  c. Pressure from Family and Friends 91
  d. Returning to the Community 91
6. Aboriginal Women and Addiction Treatment 91
7. Participants' Treatment Recommendations 93

PART 4: CONCLUSION 95

Appendix A: List of Recommendations 97

Appendix B: Consent Form (Key Informant Interview) 102

Appendix C: Service Provider Questionnaire Guidelines 103

Appendix D: Service Provider Questionnaire . 104

References 109

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Finally, I would like to thank the service providers and women who participated in the project. Each and every service provider I spoke with was very open and direct about their experiences in addressing this issue. The conversations were insightful and interesting, and illustrated the commitment of this group of people to the individuals they serve. As for the women who participated in this study, I cannot express the gratitude that I feel for the ways in which they educated and guided me through this project. Opening up to a stranger is not an easy thing to do, especially about sensitive matters; however, the women in this study did so with grace and dignity, and with a strong commitment to try to find ways to make life better for women, their children, and their families. It is to them that this report is dedicated, as it is their words of wisdom which have guided the writing of this report.

On a personal note, I would like to thank Beverly Sabourin and Peter and Jessie Globensky who opened their home to me during my stay in Manitoba. Without their friendship and encouragement, I would have been lost. I would also like to thank my husband, Adil Ben Boubaker, who supported me with his love and understanding from our home in Montreal during the research phase of the project, and who helped me negotiate pregnancy, childbirth and being a new mother while working to complete this project. Lastly, I would like to thank my son, Skender Ben Boubaker, who has brought so much to my life, including an understanding of what it is like to be pregnant, and to experience the joys of parenthood. I hope that this new-found wisdom is reflected in this report.

This report is the result of a great deal of hard work and commitment by many people to improve the services provided to pregnant women who struggle with substance addiction. While acknowledging the contribution of many, I take full responsibility for the information that is contained within this report.

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A STUDY OF THE SERVICE NEEDS OF PREGNANT ADDICTED WOMEN IN MANITOBA

EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

This study examines and describes the service needs and experiences of pregnant women in Manitoba who have problems with substance misuse. The goal of the project was to address the following research questions:

> What are the experiences of pregnant addicted women in seeking, participating in, and completing treatment for addictions, and in maintaining recovery? Attention was directed specifically to developing a profile of these women, which identifies elements of diversity among them and estimates their numbers.
>
> What range of programs and services currently exist in Manitoba for pregnant addicted women? Attention is paid to inter-sectoral efforts among government and non-government organizations.
>
> What are the particular challenges in meeting the needs of Aboriginal pregnant women with problems of addiction?
>
> Are the existing programs and services meeting the needs of pregnant women with addiction problems? If not, what barriers, gaps or duplications exist? What programs and services should be in place?
>
> What are the characteristics of effective programs and services for pregnant addicted women?

In Manitoba, substance misuse by pregnant women has been identified by service providers as a serious health concern. This is supported by medical research which has found that exposure to substances—particularly alcohol—*in utero*, can cause irreversible harm to the fetus. The Addiction Foundation of Manitoba reports that 4% of the women who entered AFM addiction programs between April 1999 and March 2000 identified as being pregnant. Given the influence of factors such as stigma and fear of child apprehension, other women may not be disclosing their pregnancies at the time of treatment. However, it can reasonably be assumed that the percentage of pregnant women accessing addiction treatment is higher, probably in the range of 5 to 8%.

Pregnant women who abuse substances heavily are at highest risk of causing harm to the health of their fetuses. These women are also at highest risk for substance abuse-related illnesses which are linked to poor quality of life and shortened lifespan. Therefore, it became a further goal of this project to draw attention to substance misuse as a serious health concern for women as well as their children.

Seventy-four women who had experienced problems with substance misuse during one or more of their pregnancies were interviewed in three geographical locations: Winnipeg, Thompson and The Pas. Eighty-five service providers who provide services to these women were also interviewed from Winnipeg, The Pas, Flin Flon, the Interlake region, Brandon, and Thompson. First Nation on-reserve services were not included in the study, nor were the experiences of First Nation women in accessing on-reserve services.

This study found that women in more advantaged socio-economic groups prefer accessing outpatient/day programs. However, they were under-represented in all areas of addiction services. Aboriginal women were over-represented in the majority of addiction treatment programs, as were women on income assistance. This is due partially to Aboriginal peoples generally being more accepting of addiction treatment for women, and Child
and Family Service (CFS) agencies directing

women on income assistance and with children in foster care into addiction treatment as a requirement to regain custody of their children.

This study found that the service needs of pregnant women who struggle with problems of substance misuse will not be fully addressed by any single service or program. In the view of women and service providers interviewed for this project, a collaborative effort among service providers is needed. Women reported overwhelmingly that the most valuable asset a service can offer is a supportive and non-judgmental environment where they feel free to work with service providers to address their needs.

This study also found that women were very pragmatic when accessing services. However, at times, their pragmatism was misread by some service providers as non-compliance or indifference when women did not choose to access available services. For women, pragmatic approaches to service provision stemmed from various responsibilities, demands, past experiences and compounding circumstances that made up the daily realities of their lives. When making decisions about what services to access, women based their decisions within this larger context. This was confirmed by many service providers who felt their service mandates were at times too narrowly defined and inflexible, given the fact that their clients did not access services as fragmented individuals, but were simultaneously dealing with various life issues.

Pregnancy for women is typically a time when they become increasingly visible to service providers and are able to access programs that will help to improve their health and well-being, and in turn, that of their fetuses. However, barriers do exist which prevent women—including pregnant women—from accessing service to help them with their substance misuse problems. Women and service providers in this study reported a number of barriers that prevent women from accessing addiction services. These were related to six areas: psychological barriers; barriers related to a woman's children; barriers related to social support networks; barriers related to socio-geographic factors; barriers related to stigma; and barriers related to treatment programs themselves.

Of the 66 women who reported trying to access addiction treatment, 59 (89%) reported experiencing one or more barriers that prevented them from accessing the treatment they sought. However, when reporting barriers to addiction treatment, women had differing views on what they considered to be factors preventing them from accessing treatment. As well, barriers identified by women were not always simultaneously identified by service providers, as many of the barriers reported by women were either not recognized as such by service providers, or were not interpreted as a barrier or as being less of an obstacle than the women reported. In other circumstances, both the women and service providers identified the same barrier, but were unable to find an immediate solution (i.e., long waiting list, lack of child care services).

This study found that pregnancy is a time when women can be motivated by service providers to seek addiction services. Data from this project suggest that centres that provide gender-sensitive outreach services are in key positions to offer frontline counselling and support to high-risk women. They also have the potential to house other services such as mentor programs, community clinics, and family support programs. Outreach centres are in a key position to work with other service providers, such as CFS, addiction services, and pregnancy programs to refer women to appropriate services which are meaningful to them. Added to this is their capacity to support and work with women while they are living in their home environments, and to provide addiction aftercare services and relapse prevention in communities where this is currently unavailable. Expanded outreach services also have the potential for building a sense of community for women who feel isolated and have limited healthy support networks. These services can also facilitate building community wellness by promoting, supporting and encouraging pregnant women to abstain from using substances.

KEY RECOMMENDATION 13: That Manitoba Health develop the service capacity of gender-sensitive outreach services that women strongly identify as being supportive and trustworthy, particularly those services that deal with specific high-risk populations and in communities with widespread substance abuse. It is further recommended that these services work in conjunction with other agencies, such as addiction treatment programs and Child and Family Services agencies to support women in building healthy support networks, and decreasing or ceasing their use of substances before, during and after pregnancy, creating stable home environments, and expanding their education and employment options.

Although barriers still exist for pregnant women, pregnant women in Manitoba are increasingly accessing addiction services, and efforts have been made to prioritize them. However, pregnant women who present while intoxicated are prevented from accessing services, including addiction treatment. Throughout the province, most services for women, such as shelters, are not equipped to deal with intoxicated clients. An emergency shelter does exist in Winnipeg that admits both men and women, but addiction services in the remainder of the province are unable to deal with this population within their current mandates.

KEY RECOMMENDATION 22: That Manitoba Health develop services for pregnant women who present for services when intoxicated, including women who are detained by police under *The Intoxicated Persons Detention Act*.

Other barriers exist for pregnant women including women not being allowed to enter some treatment programs if they are due to give birth before completion of the program. Most addiction treatment programs do not allow women to bring their newborn babies to treatment, nor do they provide child care services for women who are in treatment or accessing aftercare services. In addition, the majority of service providers, including addictions services, have done little to address the stigma directed toward pregnant women who abuse substances, or the guilt and shame that many pregnant women feel because of their substance misuse.

This study found that pregnant women generally prefer to access treatment close to where they live, although issues of confidentiality and stigma were expressed by more women in smaller urban and rural communities. Pregnant women who do not have other children in their care prefer treatment programs that allow them to stay in treatment for the duration of their pregnancy. Pregnant women with other children in their care prefer outpatient/day programs, short-term residential programs, or residential programs that allow them to bring their children to treatment. For the majority of women, lack of safe, accessible child care services was a main barrier to accessing addiction treatment.

Where CFS is involved in a woman's life, it is the central service provider to which the woman responds, and therefore has the greatest influence on whether or not she will seek addiction treatment. A large percentage of women in this study entered addiction treatment because CFS required them to do so in order to regain custody of their children, or because CFS has placed an order for the apprehension of their babies at birth unless they entered addiction treatment. Several women reported frustration, anger, and feelings of hopelessness and defeat when discussing their relationship with CFS. As well, there was a great deal of mistrust of CFS by women—particularly Aboriginal women—because of past experiences of children not being returned to their care even though the women felt they had met all of CFS's requirements. Apprehension of children by CFS was also a risk factor for increased substance abuse by women, including pregnant women.

Women with extreme substance misuse problems are likelier to be motivated to address their addiction problems after the birth of their babies than when they are pregnant. However, once women give birth, they are not given admission priority by treatment programs and are placed on regular waiting lists. These women are more likely to have their babies apprehended at birth, increase their substance use after their baby is apprehended, have children in the permanent care of CFS, and not to use any form of birth control. The lack of immediate intervention services for women who have had their babies apprehended at birth is a serious gap in service provision.

KEY RECOMMENDATION 42: Recognizing the central role of Child and Family Services agencies in the lives of women with substance abuse problems whose children have been apprehended or will be apprehended at birth, that Manitoba Health, work collaboratively with CFS and addiction treatment programs, to find ways in which support services and treatment programs can provide meaningful service options for women when an apprehension order has been made. These service options should include:

a. intensive, supportive and non-judgmental support services, including grief counselling and referral to treatment programs, for women directly following apprehension of their children;
b. preparation for women to enter addiction treatment programs to ensure that they will gain the greatest benefit from the program;
c. formal written agreements between CFS and women as to the requirements which must be met in order for a woman's children to be returned to her care, or for an apprehension order to be lifted;
d. regular visitation schedules for women and their children during the periods of apprehension; and
e. the development of support services for women and their children once addiction treatment is completed and children are returned to the care of the mother.
f. training for CFS workers in addiction prevention and treatment.

Women who participated in this study viewed excessive substance misuse during pregnancy as placing the health of their fetuses at risk and as problematic behaviour. However, compounding factors, particularly mental health and relationship problems, poverty, lack of childcare options, stigma, and geographical location often prevented women from addressing their substance misuse problems. When given meaningful treatment options by service providers they trust and respect, women, including those who are pregnant, will participate in addiction treatment to improve their own health and that of their fetuses.

This study found that women had differing experiences in treatment programs, noting that treatment programs offering specialized gender-sensitive programming and individual counseling supported by group sessions, had the most positive impact. Differing experiences in accessing and participating in treatment suggests a need for individualized treatment and wellness strategies to be developed by women with the help of service providers whom they trust. Preparation to enter addiction treatment is a gap in current service delivery, with women most often choosing addiction programs based on factors unrelated to treatment philosophies and program delivery, such as child care availability, the waiting list of various programs, geographical location, etc.

While addiction treatment services in Manitoba are incorporating specialized programming for women, according to women and service providers interviewed for this project there is a need to ensure that gender-sensitive treatment is made available to women in all parts of the province, and that these programs are more than just the absence of men from treatment programs or groups. As well, treatment strategies for women should be developed within a framework that is sensitive to issues of gender, and inter-related factors such as culture, age, and geographical location.

KEY RECOMMENDATION 47: That Manitoba Health, in conjunction with a wide range of service providers and addiction treatment programs, ensure that women at risk of misusing substances while pregnant feel safe and secure in accessing services that are meaningful to them and best support them in reducing or ceasing to use substances. Strategies should include:

a. providing a range of addiction treatment options to women;
b. ensuring services mandated to assist women in accessing addiction services educate them about available treatment options to enable them to be informed consumers;
c. requiring addiction treatment programs targeting women to develop services that are sensitive to issues of gender, drawing on proven gender-specific addiction programming currently available in Manitoba and other parts of North America;
d. requiring addiction treatment programs to include an evaluation component to determine their effectiveness and value to women participating in them;
e. making safe and accessible child care services available to women near to where they attend treatment; and
f. removing long waiting lists as a barrier that prevents women for accessing the treatment program they prefer.

Mentor programs for women who are at highest risk of using large amounts of alcohol while pregnant have recently begun to operate in Winnipeg. According to women participating in the programs, as well as service providers, these initiatives have had very positive short-term results. However, similar services for women who are at high risk of abusing other substances, particularly inhalants, or for women living in other parts of Manitoba, do not exist.

KEY RECOMMENDATION 8: That Manitoba Health support the creation of mentor programs similar to the "STOP FAS" program for high-risk women in regions of the province outside Winnipeg, and mentor programs which address other substance addictions, particularly the use of inhalants.

Effective aftercare services for women, particularly pregnant women who have completed a treatment program while still pregnant, have also been identified as serious gap in service delivery. For a large number of women in this study, lack of aftercare services and support meant that it was extremely difficult for them not to use substances, particularly if they were surrounded by friends and family members who were using, were in abusive relationships, did not have their children in their care, were unemployed, and/or lived in impoverished circumstances. While many service providers believed that pregnancy should be a strong motivation for women to stop using substances, this study found that pregnant women were often reacting and responding to other relationships in their lives, such as relationships with partners, family members, and CFS workers, and that their "relationship" with their fetus or "unborn child" tended to be less immediate and more abstract. Furthermore, being substance-free for the length of their pregnancies was extremely difficult for women who had serious addiction problems and few positive supports in their lives.

KEY RECOMMENDATION 49: That Manitoba Health, in conjunction with addiction and outreach service providers, improve aftercare services available to women, including fostering increased communication among service providers, and effective follow-up services to connect women with positive supports in their home communities.

Of the seventy-four women interviewed for this project, the majority (77%) were of Aboriginal descent. The over-representation of Aboriginal women suggests that this is a serious health concern for Aboriginal women. This study found that for Aboriginal women, substance misuse during pregnancy is related to being the most impoverished group of people in Manitoba, historical events (such as residential schools and mass adoption of Aboriginal children that undermined Aboriginal families and communities), and low levels of education and chronic unemployment found generally among Aboriginal peoples living off-reserve. It is also related to Aboriginal children being removed from the care of their mothers at higher rates than non-Aboriginal children, resulting in Aboriginal children spending longer periods of time in foster care, and being placed in multiple foster homes over the course of their childhoods.

This study found that in general, Aboriginal women preferred treatment programs that addressed their cultural beliefs and the historical realities of Aboriginal peoples. They also reported that they preferred to access services from Aboriginal organizations, specifically those that were associated with their own Nation. Aboriginal women said that they often did not identify with service providers, such as CFS workers, because their workers were usually non-Aboriginal and had a more privileged socio-economic status. Aboriginal women also reported a greater distrust of CFS agencies, and were likelier not to access support services for fear that their request for support would be understood as an inability to parent their children which could result in their children being apprehended.

KEY RECOMMENDATION 20: That Manitoba Health recognize that Aboriginal agencies, such as Métis Child and Family Services, Friendship Centres, and the Aboriginal Health and Wellness Centre in Winnipeg are in key positions to work directly with high-risk pregnant women and communities which they serve under their current mandates, and are in the best position to create meaningful programs and services for Aboriginal women and to work with Aboriginal off- and on-reserve addiction services.

This study found that pregnant women who are at risk of misusing substances do not do so because they are unaware of the public health message, or because they are indifferent to the potential harm to their fetuses. Rather, the contributing factors to substance misuse by pregnant women are complex and varied, and therefore call for services and programs which reflect this reality. Currently in Manitoba, a great deal of creativity and thoughtfulness has been directed toward these issues. However, service providers in this study agreed that for high-risk women, positive long-term outcomes are still difficult to achieve.

Service providers in this study agreed that increased communication and flexibility among various service agencies is needed, particularly with regard to addiction service providers and CFS agencies. From their point of view, all services providers must work toward a stronger continuity of care for women in general, and avenues to facilitate this should be financially and ideologically supported by policy-makers and programming.

Given a strong commitment from Manitoba Health and other government ministries, significant gains can be made to address this health issue for women and their children. By tapping into the willingness of women at risk to work toward improving the quality of life for themselves and their children, and by utilizing the positive momentum that service providers across the province have created around this issue, Manitoba Health can make meaningful improvements to outcomes of high-risk pregnancies and the health status of women with substance abuse problems.

A STUDY OF THE SERVICE NEEDS OF PREGNANT ADDICTED WOMEN IN MANITOBA

PART 1:
INTRODUCTION

A. BACKGROUND

Following the Supreme Court decision[1] in the case of *Winnipeg Child and Family Services (Northwest Area) v. G.* in September 1997, community service agencies approached Manitoba Health to express concerns with regard to barriers pregnant women experience in accessing and completing addiction treatment.[2] At a subsequent meeting between Manitoba Health and addictions service providers to discuss these concerns, the service providers suggested that it would be useful to conduct a survey of existing referral agencies, service providers and consumers to determine what services are currently available to pregnant addicted women, and to determine the specific needs of this population group that are not being met within the existing system.

In response to this advice, Manitoba Health commissioned the Prairie Women's Health Centre of Excellence (PWHCE)[3] to manage a research study to describe and examine the service needs and experiences of pregnant addicted women in Manitoba. The goal of this project was to address the following research questions:

> What are the experiences of pregnant addicted women in seeking, participating in, and completing treatment for addictions, and in maintaining recovery? Attention was directed specifically to developing a profile of these women, which identified elements of diversity among them and estimated their numbers.
>
> What range of programs and services currently exist in Manitoba for pregnant addicted women? Attention was paid to inter-sectoral efforts among governments and non-government organizations.
>
> What are the particular challenges in meeting the needs of Aboriginal pregnant women with problems of addiction?
>
> Are the existing programs and services meeting the needs of pregnant women with addiction problems? If not, what barriers, gaps or duplications exist? What programs and services should be in place?
>
> What are the characteristics of effective programs and services for pregnant addicted women?

B. PROJECT COMMITTEES

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[1] In August 1996, a judge of the Manitoba Court of Queen's Bench ordered a woman who was five months pregnant to be placed in the custody of the Director of Child and Family Services and detained at the Health Sciences Centre in Winnipeg until the birth of her child. She was to receive addiction treatment at the hospital. According to the judge, the purpose of the order was to protect the woman's unborn child from the woman's addiction to solvents. The order was set aside on appeal, but Child and Family Services requested that the Supreme Court of Canada hear the case to consider future legal issues. In June 1997, the Supreme Court dismissed the case on the grounds that an order to detain a pregnant woman to protect the fetus would require changes to the law. The Court held that such action was more appropriately taken by the Legislature.

[2] For the purposes of this report, "addiction" or "substance misuse/-abuse" refers to the use of alcohol, illicit drugs, prescription drugs, or inhalants. It does not include tobacco use.

[3] The Prairie Women's Health Centre of Excellence is funded by the Women's Health Bureau of Health Canada, and undertakes research to provide policy advice to make the health system more aware of, and responsive to, women's health needs. The Centre is a formal partnership among the Fédération provinciale des fransaskoises (Saskatchewan); the Prairie Region Health Promotion Research Centre, University of Saskatchewan; the University of Regina; the University of Manitoba; the University of Winnipeg; and the Women's Health Clinic (Winnipeg).

1. PWHCE Project Working Group

The PWHCE Project Working Group included Mary Debets (Manager of Addictions Services, Manitoba Health); Judy Hughes (Board of Directors, PWHCE); Linda DuBick (Executive Director, PWHCE); Nancy Poole (Research Consultant, Aurora Centre, BC Women's Hospital); Michael Weinrath (Professor, Department of Sociology, University of Winnipeg); Caroline Tait (principle project investigator); and Jennifer Howard (PWHCE Manitoba Program Coordinator). The role of the Project Working Group was to:

consult with the Project Advisory Committee in the development of the terms of reference for the project;
prepare and issue a Request for Proposals (RFP) to conduct the project to qualified researchers;
select the qualified researcher(s) to conduct the project;
oversee and guide the conduct of the project;
determine the emphasis, findings, conclusions and recommendations of the project;
report on the progress of the project to the Project Advisory Committee;
present project drafts and final reports, including recommendations, to the Project Advisory Committee; and
participate in a consultative process with the Project Advisory Committee in the development of communications strategies for the dissemination of project results.

During the course of the project, the Project Working Group met by teleconference call on seven occasions at which time guidance and feedback were given to the principal project investigator.

2. Project Advisory Committee

The Project Advisory Committee included Heather Block (Laurel Centre); Roberta Coulter (Addictions Foundation of Manitoba); Jean Doucha (St. Norbert Foundation); Bertha Fontaine (Native Addictions Council of Manitoba); Cate Harrington (Health Promotion Branch, Health Canada); Elaine Isaac (Manitoba Health); Marilyn McGillivary (Native Women's Transition Centre); Dawn Ridd, Michelle Dubik and Ben Van Haute (Manitoba Family Services and Housing); and two anonymous consumer representatives. The role of the committee was to:

provide advice to the PWHCE Project Working Group in the development of terms of reference for the project, including the definition of the scope of the project; the definition of the population to be studied; the formulation of key research questions; research methodology appropriate to the population under study; and the identification of key informants;
receive reports on the progress of the project from the PWHCE Project Working Group;
receive project draft and final reports from the PWHCE Project Working Group, and provide feedback on findings, conclusions, and policy and program recommendations; and
participate in a consultative process with the PWHCE Project Working Group in the development of communication strategies for the dissemination of project results.

The composition of the Project Advisory Committee was designed to bring a wide range of perspectives to the consideration of the research evidence. The members provided expertise and experience that reflected diverse interests. The consumer representatives brought an important understanding of client experiences and expectations to the discussion. Service providers and government officials were included to ensure that emerging findings and recommendations made sense to those who may be charged with implementing them. During the course of the project, the Committee met four times. Minutes were taken at all meetings and distributed to members of the committee.

C. METHODOLOGY

The goal of this research project was to explore the experiences of pregnant women in seeking, participating in, completing addictions treatment, and in maintaining recovery. This study also examined the range of services and programs currently available to pregnant women with problems of addiction to determine if existing services and programs were meeting the target population's needs, and to define the characteristics of effective programs and services. The project adopted a determinants of health approach to address the research goals, taking a holistic view of the variables that impact upon health and well-being. The framework was then applied to qualitative methodological research strategies to address the research questions.

1. Determinants of Health

In 1997, a report submitted to the Addictions Foundation of Manitoba and the Alberta Alcohol and Drug Abuse Commission stated that most analyses of the determinants of health included only minimal reference to the addictions field despite some of the most costly and pervasive heath problems in society being directly linked to substance addictions (Wiebe 1997:2). The author of this report drew on the health determinants framework in the document *Strategies for Population Health: Investing in the Health of Canadians* (Federal/Provincial/Territorial Advisory Committee on Population Health, 1994). Determinants of health were identified as income and social status, social support networks, education, employment and working conditions, physical environment, biology and genetic endowment, personal health practices and coping skills, healthy child development, and health services. These determinants interact with one another to influence a person's health and well-being (Wiebe 1997:14).

In 1996, Health Canada broadened the determinants of health to include social environment, gender, and culture. These three variables were of particular importance to this project. The revised determinants of health defined by Health Canada (1996 in Horne *et al* 1999:8-9) are:

a. Income and Social Status

Health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth.

b. Social Support Networks

Support from families, friends and communities is associated with better health. The importance of effective responses to stress and having the support of family and friends provides a caring and supportive relationship that seems to act as a buffer against health problems.

c. Education

Health status improves with level of education. Education increases opportunities for income and job security, and equips people with a sense of control over life circumstances-key factors that influence health.

d. Employment and Working Conditions

Unemployment, underemployment and stressful work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities.

e. Social Environments

The array of values and norms of a society influence in varying ways the health and well-being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Studies have shown that low availability of emotional support and low social participation have a negative impact on health and well-being.

f. Physical Environments

Physical factors in the natural environment (e.g., air, water quality) are key influences on health. Factors in the human-built environment such as housing, workplace safety, community and road design are also important influences.

g. Biology and Genetic Endowment

The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances, genetic endowment appears to predispose certain individuals to particular diseases or health problems.

h. Personal Health Practices and Coping Skills

Social environments that enable and support healthy choices and lifestyles as well as people's knowledge, intentions, behaviours and coping skills for dealing with life in healthy ways, are key influences on health. Through research in areas such as heart disease and disadvantaged childhood, there is more evidence that powerful biochemical and physiological pathways link the individual socio-economic experience to vascular conditions and other adverse health events.

i. Healthy Child Development

The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills and competence is very powerful. Children born in low-income families are more likely than those born to high-income families to have low birth weights, to eat less nutritious food and to have more difficulty in school.

j. Health Services

Health services, particularly those designed to maintain and promote health, to prevent diseases, and to restore health and function contribute to population health.

k. Gender

Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Gendered norms influence the health system's practices and priorities. Many health issues are a function of gender-based social status or roles. Women, for example, are more vulnerable to gender-based sexual or physical violence, low income, lone parenthood, gender-based causes of exposure to health risks and threats (e.g., accidents, STDs, suicide, smoking, substance abuse, prescription drugs, physical inactivity). Measures to address gender inequality and gender bias within and beyond the health systems will improve population health.

l. Culture

Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

2. Research Strategies

In collecting data for this project, the importance of a determinants of health approach to understanding the service needs of pregnant women with problems of addiction was invaluable. Several research strategies were employed in the collection of data to facilitate this approach.

a. In-depth Open-ended Interviews

The major research component of this project was a series of in-depth, open-ended interviews. Two groups were interviewed: service consumers or clients, and service providers.

b. Interviews with Consumers

During the course of the project, 74 women were interviewed on one or more occasions. The interviews lasted between 45 minutes to four and a half hours, with the average interview being one hour in length. Women were interviewed in three geographical regions: Winnipeg (41 women); Thompson (18 women); and The Pas (15 women). The women came from various age cohorts, socio-economic backgrounds, and cultural-political groups.[4]

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[4] "Cultural-political groups" refers to categories which are applied by policy-makers to different groups such as non-status First Nation people who do not have treaty rights. These categories simultaneously reflect cultural and political affiliations, but more importantly, often determine the services to which a woman has access. The following groups were identified in this project: First Nation off-reserve, First Nation non-status, Métis, and non-Aboriginal. See Table 22 for a breakdown of consumer participants.

Participants were referred to the project in three ways: by a service provider, by a friend or relative, or by self-referral upon seeing a poster or announcement calling for research participants. With the exception of two women, all participants had children and/or were pregnant, and all 74 women self-identified with current or past problems with one or a combination of illicit drugs, alcohol, solvents, or prescription drugs. Of these women, 62 reported being addicted to one or more substances. The only woman interviewed who did not have problems with substance misuse was the mother of a teenage daughter who had just returned from addiction treatment. This woman was interviewed because of her experience in helping her daughter access treatment and maintain sobriety. She is not included in the sample population.

Due to the sensitive nature of the study's research questions, locating and convincing women to participate in the study was a concern from the outset. Each participant was paid an honorarium of $40, and had the costs of child care and transportation covered when needed. Participants were brought into the project as "advisors," meaning that each was asked to draw on her personal experience with substance misuse and addiction to inform the research project. The majority of participants were interviewed alone. Six women asked to be interviewed in groups of two, and three other women asked to be interviewed with their male partners. In these cases, the discussion between interviewees was extremely valuable, as participants debated the research questions with one another. One male partner was interviewed alone, an arrangement made by his partner who had previously been interviewed. Although male participants were not included in the consumer group, the opportunity to interview them provided useful insights for the project.

Confidentiality was of great importance in the interview process. Each participant was asked to sign an agreement of confidentiality with the researcher (see **Appendix B**). One copy was given to the participant and the other was retained by the researcher. Each participant was also given the opportunity to be sent a transcript of the interview or a copy of the taped interview.

A further concern was the obligation, once in receipt of the honorarium, that participants might feel to give personal information they were not comfortable in providing. It was recognized that the honorarium would draw participants from lower socio-economic circumstances, but would not necessarily attract participants who had greater financial security. Some participants would be torn between wanting to collect the honorarium and not wanting to discuss details of their personal lives for inclusion in a research project. In order to counter this problem, participants were given the opportunity to decline to be interviewed at any time, including immediately after receipt of the honorarium. Participants were also told that they did not have to answer any questions that they did not feel comfortable in answering, and that they could ask that the tape recorder be turned off at any time, or to request that it not be used during the interview.

As a result, it was found that by offering an honorarium, the project was able to access a group of participants who were not referred by service providers. These participants tended to be women who were using substances on a regular basis, and who had fallen through the cracks of service provision. None of the 74 women terminated the interview after receiving the honorarium. They were very interested in having their experiences and knowledge heard by service providers and policy-makers.

Unstructured interviews were used with consumers. According to Bernard (1988:204), this style of interview seeks to have people open up and express themselves in their own way, on their own terms, and at their own pace. Others, such as Keesing (1992:10), argue that subjective narratives help to control against excessive projections of both the ethnographer's theoretical biases, and the logic, assumptions, motives and categories of the dominant mainstream society onto local groups. Lock (1993:xxxix) points out that subjective experience cannot be measured by scientific methods but must be narrated. This kind of information, usually neglected by biological and social scientists alike, allows us to enter vicariously into the lives of individuals. Subjective narratives do not permit broad generalizations and abstractions, but encourage a contextualization of specific pieces of the puzzle and provide an important constraint on the way in which we obtain and interpret biological and statistical information (Lock 1993:xxxix-xl). Lock (1993:xl) and Scarry (1985) add that because the experience of subjectivity—and the language that is used to describe it—is a cultural product, personal narratives are inevitably circumscribed in specific ways, with narratives emphasizing certain features while leaving others unrecognized or unspoken. What people (in this case, women with problems of substance misuse) experience and report in connection with their bodies is not in essence the same type of information produced through observation, measurement, and abstraction (Lock 1993:xxiii). For example, more formalized interviews which follow a strict interview guide make arbitrary decisions concerning criteria for inclusion and exclusion, which may simultaneously act as moral decisions about what is normal and abnormal (Lock 1993:xxiii), or may prevent connections and associations which are apparent or logical to the informant, but not the researcher, to emerge during interviews.

Further reasons for the use of this style of interview were that unstructured interviews allow for a more relaxed and informal interaction between the researcher and the person being interviewed. This was particularly important for building a positive rapport and level of trust with participants. Another benefit of this approach was that the reasons for interviewing these women differed from those for interviewing service providers in that it was the subjective, rather than the professional, experiences of the women that was important.

The participants' response to this interview style was very positive. Many were surprised at how comfortable they felt throughout the interview. Upon completion of the interview, each participant was given a telephone number where they could contact the researcher if they had any follow-up questions, information that they wanted to add, or if they decided to remove their interview from the project.

c. Interviews with Service Providers

The second group interviewed for this project was service providers who work directly with the consumer group. Eighty-five interviews were conducted in different geographical areas: Winnipeg (43), The Pas (12), Flin Flon (one), the Interlake region (seven), Brandon (10) and Thompson (12). Several meetings were held with service providers who were not directly involved in the project, particularly First Nation health and social service providers on reserve. These meeting were designed to notify First Nation service providers about the project and that First Nation women were included in the consumer population. No First Nation women were interviewed in their reserve communities, and the interviews with seven women from reserve communities focused on their experiences accessing off-reserve health and social services. In some cases, the experiences of First Nation women living off-reserve who had accessed addiction treatment on-reserve were included.

Prior to commencement of the project, approximately 20 categories of service providers were identified by the Project Advisory Committee as potential key informants for the project. In scheduling interviews, this list was considered at all times. In particular geographic areas, service providers in certain categories were more appropriate to interview than their counterparts in other geographic areas.

Interviews with service providers were conducted mainly at the site where the consumer group would access services. This gave the researcher the opportunity to receive a tour of the facility and to see where interactions occurred. Interviews with service providers were as short as 30 minutes and as long as three hours. Some service providers were interviewed more than once, while others—especially those in Winnipeg—were contacted by telephone to gain further information as the project progressed. The majority of service providers interviewed dealt with the consumer group because of the women's problems with substance misuse or pregnancy. Some service providers, such as women's shelters, dealt with the consumer group for reasons not specific to substance misuse or pregnancy. These interviews were particularly important in identifying services other than those related to substance use during pregnancy that women might be accessing.

Interviews with service providers were semi-structured, using a more formalized style accompanied by an interview guide to lead the discussion. According to Bernard (1988:205), this form of interview is particularly useful when interviewing managers, bureaucrats, and elite members of a community, namely those people who are accustomed to efficient use of their time, while permitting the researcher the discretion to follow leads. This style recognizes that each group of professionals has its own professional discourse, practices and technologies into which an understanding of the consumer group and its needs has been incorporated. Semi-structured interviews allow for comparative analysis of important topics, such as the ways different professions conceptualize consumers as being high-risk or as candidates for particular services. Many professionals and paraprofessionals who were interviewed had busy schedules and placed strict time limits on the interviews. They expected that there would be a set agenda for the interviews, and the format demonstrated to them a level of professionalism, organization, and respect for their time.

The questions included in the interview guides were developed specifically to determine:

the services and programs that the agency or organization was delivering to the consumer group;
the importance of geographical location in service provision;
the services' and programs' target populations, and how the project consumer group fit into that population; and
what the experience of the service providers were in the delivery of services to the project consumer group.

d. Service Provider Questionnaire

During the project, a "Service Provider Questionnaire" (see **Appendices C and D**) was developed and sent to 80 service providers. The questionnaire provided supplementary data to the interviews with service providers, particularly from those who were not interviewed because of geographical location and/or time constraints. Twenty-five percent of the questionnaires were completed and returned. Although this is well below the anticipated response rate, the completed questionnaires provided valuable information that supports the other research methods.

e. Focus Groups

Two focus groups were held with consumers in Winnipeg and Thompson. The focus groups were designed to allow consumers to discuss the research questions collectively and to put forth recommendations that they felt would be beneficial to pregnant women with problems of substance misuse. Each participant was paid an honorarium of $20 for participation in the focus group.

The focus group in Thompson included six women and one male partner of one of the women. All but one woman was Aboriginal, and the focus group lasted approximately 90 minutes. Many of the participants who attended had grown up in families with addiction problems, and in some cases, had been placed in care as children. As adults, they were all dealing with problems related to substance misuse and the pressures of raising young children. The focus group began as an informal discussion about the issues of pregnancy and substance misuse, but quickly expanded into inter-related topics such as child apprehensions, poverty, and education.

Fourteen individuals participated in the Winnipeg focus group (12 women and two transgender persons). The focus group lasted approximately 90 minutes and included discussion and recommendations from participants. Many of the women in this focus group had been interviewed previously, were familiar with the goals of the project, and also knew one another.

f. Participation in Community Meetings and Conferences

During the course of the project three community meetings (two in Winnipeg and one in Riverton) were attended by the principal investigator. These meeting were helpful in making connections with various service providers, and provided an opportunity to highlight issues identified by community coalitions, professionals and paraprofessionals.

g. Collection of Written Information

Documentation was collected from service providers, including publications, public health pamphlets, and teaching and information tools. Attention was paid not only to the type of information being disseminated by service providers, but also how the information was being disseminated to the general public and to other agencies and service providers.

3. Sample Population

Women were referred to the project in three ways: by a service provider, by a friend or relative, and by self-referral upon seeing a poster or announcement calling for research participants. The project did not have a random sample population in which everyone had the same chance of being selected to participate (Bernard 1994:84). The drawback to this approach is that certain subgroups maybe under-represented or not represented in the sample. This is true for this project with respect to women who were socio-economically advantaged, women from various ethnic groups, and women located in certain geographic areas of the province. Due to the specific criteria for inclusion in the sample population (that the woman be either pregnant or have had been pregnant in the past while struggling with problems of substance misuse), it was virtually impossible to use random method sampling.

Judgment sampling was used, where the researcher decides the purpose an informant (or community) will serve, and then locates participants accordingly (Bernard 1994: 97). This type of sampling has been used in life history and qualitative research on special populations such as the target population for this study. The benefit of such an approach is that it allows the researcher to seek out as diverse a sample population as possible. A second type of sampling, called "snowball" sampling, was also used, where the researcher located one or more key individuals and asked them to refer others who would be likely candidates for the project (Bernard 1994: 98). This method was effective in locating both service providers and consumers, and was also useful in understanding social networks between service providers and members of the consumer group. It also resulted in consumers who were not accessing services being referred to the project.

Despite the benefits of the sampling methods used, certain consumer groups were under-represented in the study. This deficiency was partially addressed through interviews with service providers to determine whether substance misuse during pregnancy was a concern among the under-represented group in the consumer sample. In some cases, it was still unclear as to whether the absence of a particular population (e.g., women from a particular ethnic group) was because they did not exist, or because they were not accessing service, and therefore, were not visible to service providers.

4. Methodological Limitations

a. Geography

Although the scope of this project included the entire province, it was not possible, due to time and financial constraints, to interview women and service providers in every community in Manitoba. The project covered representative communities in both southern and northern locations, as well as urban and rural areas. The limitations of this approach was that barriers and/or gaps specific to particular communities or areas may not have been discovered. However, through interviews with consumers and service providers who had experience from all regions of the province, this limitation was addressed to a significant degree.

b. Time

A second limitation was the time spent and techniques applied to understand service provision. While the interviews yielded important insights into services and the experiences of consumers who access them, there are limitations in relying mainly on interview data that is not supported by participant observation. The benefit of participant observation (a research method in which the researcher participates in the everyday activities of a research setting while observing the ways in which a community or group of people go about their daily lives) was only part of the project in a limited way. For example, rather than relying solely on reports by consumers and service providers, information about addiction treatment could also have been obtained through the researcher's participation in group sessions and everyday program interactions. This research method helps to support what the researcher learns from interviews and other research strategies.

Participant observation in settings such as addiction treatment centres presents several ethical problems related to client confidentiality and consumers' rights. While it is not impossible to create safeguards that protect both clients and service providers, given the timeframe and geographical scope of this project, it was not possible to spend considerable time observing service provision in any one organization or agency. The drawback is that the research relies on accounts given in interviews with individuals who provide information on specific aspects of service provision while downplaying others. While a clearer picture of service provision could be gained through participant observation, the technique requires extensive time for the researcher to understand the complexities of the varying components of service delivery.

c. Validity of Data

In the course of this project, the question of the validity of the data was raised as an issue by both the Project Advisory Committee and some participants. Given the qualitative nature of this project, and the reliance on data obtained through open-ended interviews, it was necessary to build into the methodological framework a means by which data could be said to be valid or reliable. The main way in which this was accomplished was through comparative data from interviews. For example, the experiences of different women who participated in the study were compared to look for levels of consistency among participants. Secondly, the experiences of service providers who deal with the same consumer population were compared and analyzed for consistency and areas of departure. Third, the collective experience of service providers and that of the consumer group were compared. Fourth, findings from recent ethnographic studies and resource literature which targeted similar consumer populations in different geographical regions were used as comparative sources of validity. Fifth, consistency within individual interviews was analyzed, which in some cases produced contradictory claims by individuals being interviewed. However, this should not be taken as misrepresentation by the person being interviewed—it often reflects the dynamics of the interview/interviewee relationship. It was found that when service providers and consumers relaxed during the interview, they were likelier to report information that may implicate them in a negative way. For example, service providers were often reluctant to report areas of service provision where they were having less or no success with the target population. This often changed as a service provider became more comfortable with the researcher, were asked a few questions by the researcher, and came to understand that the aim of the project was not to evaluate their services. Similarly, consumers sometimes under-reported their use of substances early in the interview, and subsequently changed this information as they became more comfortable with the interview process and felt safe to disclose the extent of their use

D. STEPPING AWAY FROM THE CONCEPT OF ADDICTION

The goal of this project was to look at the question of substance addiction as it relates to pregnant women in Manitoba. For several reasons, a focus on substance addiction, rather than substance misuse, posed several methodological problems and limitations in the collection of research data. The concept of addiction exists both as a scientific term used in clinical research, as a technical term used by paraprofessionals in service provision, and as a lay concept widely used in everyday language. While there is considerable overlap in how the concept is defined, there remains a significant degree of controversy among service providers and consumers as to the scope of the concept. For this reason, the project moved away from the concept of addiction and instead looked at substance misuse, which was broadly defined as the use of substances by a woman that put her health and/or well-being (or that of others around her) at risk. Using a determinants of health approach to substance misuse, the project was able to bypass the controversy around what constitutes an addiction, and instead focused on the outcome of substance misuse. By resituating the research question, it became easier to place in context the subjective experience of women, particularly with respect to their decision-making and response to the wide array of program and services. This approach did not deny the physiological and psychological realities of substance addiction—it respected this reality in the lives of many of the women interviewed. Overall, this approach allowed for more flexibility in understanding the ways in which women negotiate their way through the various services and programs offered to them.

PART 2: THE RANGE OF PROGRAMS AND SERVICES AVAILABLE TO PREGNANT WOMEN WITH SUBSTANCE MISUSE PROBLEMS

In Manitoba, there is a range of programs and services available to pregnant women with problems of substance misuse. The system serving this target population includes addiction programs and services, pregnancy outreach programs, Child and Family Services (CFS), transition houses and women's shelters, physicians, public health nurses, community clinics, women's resource centres, and self-help/support groups. The availability of these services and programs vary depending on geographical location. Winnipeg has a larger range and number of services and programs than any of the other geographical regions of the province.

The services provided to pregnant women with problems of substance misuse can be divided into four categories: prevention programs, secondary prevention/early intervention programs, detoxification and treatment programs, and aftercare programs and services. Service providers were interviewed from all four categories, and each category was represented geographically by at least one service provider.[1]

Eighty-five service providers were interviewed for this project. From these interviews, as well as from other data sources (such as the "Service Provider Questionnaire"), a breakdown of service provision was derived. A general understanding of how the various types of services fit into a continuum of care for the target population was developed. Specific attention was paid to intersectoral efforts by different service providers, particularly among government and non-government organizations. While this project did not conduct an evaluation of service delivery, it did approach service delivery with a critical lens. A central aim of the project was to question what is taken for granted by service providers in relation to what they feel are the "needs" of the target population, as well as to understand what service providers feel they are trying to prevent, control, improve upon, or change in the lives of the women they serve. Findings from this project suggest that there is no clear consensus as to what the needs of the target population are among service providers. Furthermore, there is no consensus as to the strategies that should be adopted to prevent or deal with substance use during pregnancy.

The following section examines the continuum of care for pregnant women who have problems with substance misuse. While this survey of services is not exhaustive, it includes the major programs and services that the target population typically accesses (see Figure 1). Information gained from interviews with service providers are incorporated into the analysis which highlights issues that are both general to Manitoba and those which are specific to particular regions or communities.

A. PREVENTION PROGRAMS

Several prevention programs and campaigns to prevent substance misuse by pregnant women have occurred over the past decade, with the majority created in the past five years. Most of the programs currently in operation focus on the misuse of alcohol, and the prevention of fetal alcohol syndrome (FAS) and related illnesses, such as fetal alcohol effects (FAE), and alcohol-related birth defects (ARBD). While some attention is paid to illicit drugs, solvents, or prescription drug use during pregnancy, these prevention strategies are limited in relation to the amount of attention directed toward the prevention of alcohol consumption during pregnancy.

1. Defining Risk

There are differing views about substance use during pregnancy among Manitoba service providers. Nowhere is this more evident than in prevention strategies. Underlying these differing views are various notions of what constitutes risk behaviour by pregnant women, specifically with respect to the amount and type of substance used. For example, some service providers, including some medical professionals in this study, saw risk as the consump-

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[1] It should be noted that the collective experience of service providers referred to in this study is a representative experience of service provision in Manitoba. A great amount of effort was invested to make this project as representative as possible of all regions and communities in Manitoba. However, it was not possible within the framework of the project to account for all experiences of all service provision.

FIGURE 1: SYSTEM OF CARE SERVING WOMEN OF CHILDBEARING AGE WITH ALCOHOL AND SOLVENT PROBLEMS

Pregnancy outreach programs
Interagency outreach
Transition houses & shelters
Drop-in centres
Safe houses
Community centres
Family centres
Youth centres
Mentor programs
Child and Family Services
Justice system
Correctional services for women
Physicians & other health care workers
Community clinics
Midwives
Day care
Child & mother support programs
Aboriginal Head Start
Employment assistance
Educational upgrading

Detox Units
Medical
Non-medical
Emergency shelters (Winnipeg only)

Day/Outpatient Treatment
Individual & group counselling (individual/group)
Referral
Aftercare
Relapse prevention

Self-Help/Support Groups
AA, NA, CA, Alateen, Al-Anon
Women for Sobriety
12-step programs
Adult Children of Alcoholics
Healing circles

Residential Treatment
Short-term (under 30 days)
Long-term (over 30 days)
Aboriginal/women/youth/ general

Supportive Recovery Programs
Life skills training
Transition to community
Short-term residential

Private therapists

Private out-of-province addiction treatment

GAPS IN SERVICE
Counselling services to assess and prepare women for treatment
Child care for women in treatment
Detox units outside Winnipeg
Women-only and gender-sensitive treatment
Outreach services in small urban and rural centres
Evening and weekend treatment for women who are employed/attending school
Referral to treatment from physicians
Emergency shelters for intoxicated pregnant women
Services for women with substance misuse problems and mental illness
Transition and aftercare services
Communication and flexibility among addiction service providers
Addiction programming specific to the needs of pregnant women

tion of *any* substances while pregnant (meaning that one drink of alcohol, or smoking one marijuana cigarette, had similar potential to cause some permanent harm to the fetus). Because medical researchers have not been able to say for certain what the safe level of substance use is for pregnant women, these service providers argue that any substance use must be considered risky behaviour. In some cases, service providers have extended the period for prohibitions against risk behaviour to include the six months prior to conception and encourage women to cease using substances during this time as well as during their pregnancies.

Some service providers argue that risk corresponds to the amount and type of substance used in conjunction with other variables, such as the age of the woman, her nutritional status, her patterns of substance use, the extent of her support networks, and generational substance abuse in her family. These service providers argue that women who are at risk are women who significantly misuse substances during pregnancy, and that the risk is compounded by these other variables. In their view, prevention strategies which target all women and call for complete abstinence by pregnant women, do little to address the complexity of why pregnant women misuse substances, or fail to consider the significance of other compounding factors.

Other service providers take the position that all substances, whether alcohol, cannabis, or solvents, are equally dangerous to the health of the fetus. From their point of view, it does not matter what substance a pregnant woman uses—all substances are potentially dangerous to the fetus. Some service providers take a harm reduction view that assigns different levels of risk to different substances. For example, some argued that smoking marijuana was less harmful to an unborn child than smoking crack-cocaine or drinking alcohol. Among harm reduction advocates, some service providers argued that risk needs to be understood in relation to both the health of the fetus and the health of the woman. In some cases, decreasing risk to the fetus by advocating that a woman use a different substance may actually increase the health risk to the woman and *vice versa*.

Lack of consensus existed among service providers as to the times when fetal development was likeliest to be affected. Some service providers counseled women that the first trimester, particularly the early weeks, was the time when the fetus was particularly vulnerable to substance use. Other service providers counseled women that substance use in the first three to four weeks (before most women know they are pregnant) is a relatively low-risk period, and it is later in the first trimester and subsequent weeks that damage is most likely to occur.

Some service providers admitted that the public health message they were communicating to pregnant women and the general population was a worst-case scenario whereby all substance use during pregnancy was portrayed as risky behaviour. This was despite their own personal belief that limited use of certain substances, such as alcohol (which is known scientifically to be one of the most harmful substances), presented virtually no risk to the fetus or to the woman. The reasons behind this strategy, they stated, was that pregnant women and their support networks would take a worst-case scenario message much more seriously than a message that was ambiguous and tolerated limited use.

The differing views of service providers as to what constitutes risk behaviour by pregnant women who consume substances presented several problems for consumers. Women interviewed reported that the public health messages they were receiving were very confusing and often contradictory. These messages generally differed from their own empirical experience or that of other women they knew. For example, some women reported that they misused alcohol during their pregnancies and gave birth to babies who grew into perfectly healthy children. However, in response to their experience, service providers warned them that their children were potential "time bombs" that could manifest behavioural symptoms associated with FAS or FAE at any time. In response to this message, women continued to feel guilty about their alcohol use during their pregnancies, and were hypersensitive to behavioural changes in their children, fearing that normal childhood development would turn into pathological manifestations of FAS.

Some service providers reported having women inquire about terminating wanted pregnancies because they had used substances before realizing they were pregnant. Questions such as this were increasing as the public health message became better known in the general population. There are no research studies in Manitoba that determine whether or not women are terminating pregnancies because of substance misuse. However, for some service providers, counselling women who want to continue their pregnancies, but are considering abortion based on their substance misuse, is a "slippery slope." In some cases, service providers felt they had to soften their message about substance use during pregnancy to reassure women that continuing a pregnancy was a viable option. Some service providers reported women understanding this to mean that the risks were in fact less than indicated in the public health message, and therefore, continued use was less risky.

Some service providers encouraged women to have abortions, particularly if the woman used substances daily and in large quantities, while others who were against abortion encouraged the same women to continue their pregnancies despite the risk. In all cases, women were encouraged to decrease or stop their use if they planned to continue the pregnancy. The advice given to women about abortion was often influenced more by the service provider's moral beliefs about abortion, or his or her perception of whether the woman had the ability to stop using during the rest of her pregnancy than any other factor (including scientifically-based evidence of risk). This resulted in many women receiving conflicting and competing advice when making this difficult decision.

Recommendation 1: That Manitoba Health develop a standardized "guideline of risk" for service providers who counsel pregnant women concerning risk and pre-natal substance exposure.

Prevention of substance use during pregnancy in Manitoba can roughly be divided into three areas: prevention directed at school-aged children and adolescents; prevention directed toward pregnant women and women of childbearing age; and prevention directed toward community wellness.

2. Prevention for School-aged Children and Adolescents

Strategies to prevent substance misuse during pregnancy directed toward school-aged children and adolescents are believed by most service providers to be a key area where changes in attitudes and behaviours can be made. The current trend in prevention education is to use negative fetal outcomes as motivation for these changes. Findings from this project suggest that this approach has taken priority over other types of prevention strategies, such as education about the underlying causes of substance misuse during pregnancy and where pregnant adolescent girls can access addiction services. Some service providers who work with school-aged children and adolescents point out the importance of understanding the role of health determinants (such as healthy childhood development, social environments, culture, and gender) in the lives of this group when designing prevention programs.

Prevention of substance use during pregnancy has increasingly targeted school-aged children and adolescents in the hope of positively influencing their behaviour both now and in the future. In general, service providers who participated in this study felt that some prevention education should begin with pre-teen children and then increase through the high school years. Some Manitoba schools have included substance use during pregnancy as an area of public health education in sex education, health classes, and family studies courses. This information is usually presented by a member of the Addictions Foundation of Manitoba (AFM) or by a public health educator.

a. Health Education

According to service providers, public health education in schools has raised awareness among the school-aged population. However, they argue that the time schools dedicate to this topic is limited as it must compete with other health issues covered in the school curriculum. Not all students opt to participate in these courses, and therefore not all students maybe reached by this education initiative.

Information obtained from service providers indicated that prevention education for school-aged children and adolescents generally focuses on the health risks of alcohol during pregnancy, rather than substance use in general. In an examination of the information presented during these education sessions, it was found that fetal, infant and child development and growth are discussed to illustrate the harmful effects of substance misuse during pregnancy. In some cases, terminology such as "structural abnormalities," "neurological brain abnormalities," and "altered morphogenesis" are used in the presentation and distributed literature. This use of technical language is beyond the comprehension of many school-aged children and adolescents. It can also present problems for educators who are trying to hold the attention and interest of the audience.

According to some service providers, a strong focus on fetal outcomes can have a negative effect in educational settings where time constraints prevent educators from explaining variation in fetal outcomes, and where risk is described as *any* use of substances during pregnancy. These service providers are concerned with the negative images of individuals with FAS or FAE that this type of prevention education gives to school-aged children and adolescents, particularly because the information tends to use the developmental profile of individuals who are the same age as the target audience. This prevention strategy assumes that it will reduce rates of FAS/FAE babies from being born. However, the school prevention strategies reviewed in this study all lacked evaluation components that would determine their effectiveness.

In general, presentations to school-aged children and adolescents do little to address the reasons why someone who is pregnant may misuse substances. Substance misuse and addiction are usually discussed at a different time in a more generic discussion of addiction. Information about where a pregnant woman could receive help to stop using substances is generally not discussed in detail. In this study, some teenaged girls reported having little or no knowledge of where they could find help for an addiction problem, even though they had received public health education in school about the dangers of substance use during pregnancy. A number of the younger consumers reported difficulty accessing treatment programs, specifically programs for youth. Some of these participants reported that they ended up going to treatment programs where they were the only persons under the age of 30, and in some cases, the only females in the program. In one case, a mother of a teenaged girl explained that she had great difficulty finding a service provider in her community who could help her find appropriate addiction treatment for her daughter despite the fact that her daughter had received public health education on substance misuse and addiction at school.

Recommendation 2: That Manitoba Health ensure that prevention strategies that target school-aged children and adolescents include ongoing evaluation of their effectiveness.

Recommendation 3: That Manitoba Health ensure that prevention education directed toward adolescent girls includes information about accessing gender-sensitive youth treatment programs that address pregnancy and addiction as a treatment concern.

Recommendation 4: That Manitoba Health advocate that prevention programming directed toward women, particularly adolescent girls, be sensitive to issues of gender and the complexities of the problem which the prevention initiative is designed to address.

b. Birth Control Education

A second type of prevention strategy that targets school-aged children and adolescents is birth control education and intervention. However, information about birth control is typically not given during health education sessions on substance misuse during pregnancy. Birth control as a prevention strategy for adolescent girls is mainly used by physicians and community clinics. For example, a recent response to large numbers of teen pregnancies in some communities has been to prescribe DepoProvera®[2] to adolescent girls, some as young as 13 years old. This birth control measure eliminates the need to remember to take a pill every day or to negotiate condom use with male partners.

Among service providers and consumers, there were mixed feelings about the use of Depo-Provera® because of the potential side-effects, and because it did not offer protection for other health risks such as the prevention of sexually transmitted diseases. Some service providers felt that prescribing DepoProvera® was a responsible response to help prevent FAS and related illnesses in social environments where teen pregnancies and substance misuse were particularly high. Both service providers and consumers pointed out that DepoProvera® was prescribed to Aboriginal women at much higher rates than non-Aboriginal women, which raised questions about the underlying motivation behind these higher rates of prescription. From the perspective of some service providers, DepoProvera® or any long-term birth control intervention did not address addiction problems among the target population, and therefore was only beneficial as a short-term solution in the prevention of illnesses related to substance use during pregnancy. They argued that DepoProvera® did nothing to address the negative health and wellness consequences of addiction for women beyond the prevention of harm to the fetus.

Recommendation 5: That Manitoba Health advocate that prevention strategies directed toward women, particularly adolescent girls, simultaneously address substance misuse and family planning.

c. "Baby Think It Over"

Another recent government prevention strategy which targets adolescents is the "Baby Think It Over" doll. This doll has been "introduced as part of a broad program to teach adolescents about the risks of early pregnancy and drinking during pregnancy" (Manitoba Child and Youth Secretariat, 1999). According to the manufacturer, the doll "represents a small-for-gestational-age full term infant with facial deformities typical of severe cases of FAS." The doll cries, has a delayed response to care, and trembles. The doll is also used in the "STOP FAS" programs, and programs working with foster parents to "both prepare mothers for parenting babies with FAS and as a tool for prevention" (Manitoba Child and Youth Secretariat, 1999).

While the "Baby Think It Over" doll presents a powerful image of FAS or drug-affected babies, it focuses on the outcome of substance use during pregnancy rather than the underlying reasons why pregnant women may misuse substances. It presents an image of a baby who is severely affected, which according to the findings of this project, would contradict the experience of most women who have misused substances during their pregnancies. For example, 58 of the 74 women interviewed (76%) reported that one or more of their children thus far had not manifested symptoms that would suggest they were affected by exposure to substances *in utero*. Sixteen women (24%) did report that one or more of their children did have some symptoms. However, many of these symptoms did not occur in infancy and it was unclear if they were caused by the woman's substance misuse. Six women (8%) reported that one or more of their children had been diagnosed with FAS. Three women (4%) had newborns with facial deformities typical of severe cases of FAS, but the children were not diagnosed. Eight women

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[2] A prescription of DepoProvera® lasts for three months and is given through injection.

(11%) reported that their newborns had experienced some symptoms associated with substance withdrawal, and two women (3%) reported that their children had a delayed response to care as a newborn.[3]

A second feature of "Baby Think It Over" is the microchip in the doll to register "child neglect" and "child abuse" of the doll by the person assigned to care for it. The assumption made by the creators of the doll must be that substance misuse and child neglect and abuse are closely tied. This is a very negative view of the mother and assumes that what is registered is somehow linked to substance misuse by the person caring for the doll. The microchip also fails to register the positive things that "the mother" is doing for the doll ("the baby") or the extent or lack of support a particular woman may have to help her parent her child. According to some service providers, the "Baby Think It Over" doll sends a negative message of surveillance similar to that of Child and Family Services agencies which monitor women on social assistance for signs of child neglect and child abuse. The prevention message built into the design of the doll sets adolescents girls up for failure because the doll is designed to be so difficult to care for that the girls are overwhelmed by its needs. Rather than supporting adolescent girls through education that positively reinforces their role as potential mothers, the doll reinforces a relationship of fear and judgement directed only at women. Some service providers argue that this doll places responsibility solely on the shoulders of the mother not only for the illness, but also for the care of the affected infant. Therefore, the prevention component of the doll is not in providing supportive information and understanding to adolescent girls about how to deal with an addiction while pregnant, but rather operates as a scare tactic to illustrate the negative outcome of what the creators of the doll see as irresponsible behaviour by pregnant women.

From the perspective of some service providers, the "Baby Think It Over" doll is a prevention initiative that reduces substance misuse to a simple choice by pregnant women. The doll, they argue, is the product of assumptions taken for granted in the larger society about the relationship between pregnancy and addiction in the lives of women. This logic assumes that if adolescent girls are presented with a realistic worst-case scenario of the harm caused by substance misuse, there will be a greater chance that they will choose not to use substances when they become pregnant. It also assumes that adolescent girls are unfamiliar with caring for newborn babies, particularly babies who are difficult to care for. In some cases, service provider reported that adolescent girls told them that the program was ineffective. These girls had already been caring for real babies for many years—usually younger siblings or cousins—and knew the experience and demands of caring for a newborn baby.

Recommendation 6: That Manitoba Health advocate for a re-evaluation of the use of the "Baby Think It Over" doll in prevention programming directed toward adolescent girls.

3. Prevention for Pregnant Women and Women of Childbearing Age

Prevention strategies that target pregnant women and/or women of childbearing ages have taken various forms over the past ten years. Some of the most current strategies include pubic health messages (television, radio and poster campaigns, information pamphlets, mentor programs) and community wellness programs.[4]

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[3] The purpose of pointing out the discrepancy between the image of the "Baby Think It Over" doll and the general experience of women at risk is not to suggest that health problems caused by substance misuse during pregnancy are somehow minimal or that they cannot be as severe as the doll presents them. The point is that public health messages that present worst-case scenarios which do not correspond with the general experience of the target population risks communicating an ineffective message.

[4] Some of these prevention programs can also be considered secondary prevention or early intervention programs, such as the "STOP FAS" program.

a. Public Health Messages

There are several ways in which a general public health message about the danger of substance use during pregnancy has been disseminated. Current strategies have included television, radio and poster campaigns and information pamphlets. This information usually is disseminated by government offices and agencies, health care providers, addiction services, and frontline and community organizations. This project found that the majority of service providers who work with the target group have some type of public health literature or poster visible to the public that addresses substance use during pregnancy. However, in the majority of situations, substance use during pregnancy has been narrowly defined or reduced to dealing with the use of alcohol during pregnancy. This is partially due to larger numbers of women using alcohol as opposed to other substances, and to scientific literature that supports findings that alcohol use during pregnancy is more harmful to the fetus than most other substances. Far less attention is given to the harmful effects of other substances, such as inhalants, cannabis, and cocaine. Not one poster was found during this study that addressed the use of other substances during pregnancy. Only limited information explaining the dangers of binge use during pregnancy was available, and was not seen in poster form. All of this information, including referral information, also assumes a level of literacy on the part of the reader which may present a barrier for those who have limited reading skills.

Information obtained from consumers suggests that prevention strategies related to the dangers of substance use during pregnancy have reached a wide range of women, including those women who are viewed by service providers to be at the highest risk. Only nine of the 74 women interviewed (12%) for this project reported that they had no information about the dangers of substance use while pregnant during one or more of their pregnancies.[5] This finding was supported by service providers who generally felt that pregnant women had a greater awareness of the dangers of substance use during pregnancy than they did five years ago.

Nonetheless, many service providers felt that education and the dissemination of information were not wholly successful in changing the attitudes and behaviours of pregnant women, particularly women who were at highest risk. Some service providers argued that public health strategies would be more effective if they were tailored to the needs of different segments of the population, rather than having a single generic public health prevention message for all women. For example, service providers pointed out that the large majority of public health messages treat women as a homogeneous group and do not consider factors such as age, socio-economic status, typical use behaviour, ethnic differences, and whether the woman has an addiction problem.

Some service providers felt that public health campaigns, such as the "Kangaroo" poster (the central public health poster used by the Government of Manitoba) do not convey a message that is clear and straightforward, and that these campaigns tend to place the woman and her fetus in an antagonistic relationship in which the behaviour of the woman is in direct conflict with the needs of the fetus. Others argued that the majority of public health posters trivialize the message they are trying to convey. For example, the image of the happy kangaroo minimizes the ongoing struggle some women have with substance addiction. Still other service providers felt that public health campaigns, such as the "Kangaroo" poster, implicitly assume that substance use during pregnancy is an uncomplicated choice for all women—a view which does not reflect the reality and complexity of addiction. These campaigns, they argue, squarely situate responsibility on the shoulders of the pregnant woman by first isolating her in the message, and then suggesting that being pregnant provides moral motivation for any woman to stop using substances to protect her unborn child. Women who cannot accomplish this are selfish, undeserving and deviant. Within this message, physiological, psychological, and emotional factors that contribute to substance misuse are trumped by the moral imperative that a woman must place the needs of her unborn baby above that of her own.

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[5] These women tended to have increased awareness with subsequent pregnancies, as did other women in the study.

Other service providers felt that the public health message was not powerful enough to impress upon women the high level of risk to the fetus that substance use during pregnancy presents. This group of service providers would prefer to see a stronger message that shocks women and the general public into seeing this as a serious health and social problem. They take the position that illnesses such as FAS/FAE are completely preventable, despite all the factors that contribute to most women's substance misuse. This group of service providers strongly believes that there are no acceptable reasons that pregnant women can give that justify their substance use. Service provider who take this stance are usually those individuals who do not work directly with high-risk women, but rather, are in government or non-government administrative and supervisory positions.

According to information collected for this project, public awareness concerning substance use during pregnancy has increased among all segments of the Manitoba population during the past five years. This is mainly due to the multiple efforts of public health education campaigns. However, this positive finding it is not without certain drawbacks, some of which may contribute to barriers women face in accessing addiction treatment. Public health messages tend to identify the problem, but do not give any information about what women can do if they cannot stop using on their own. Some service providers have addressed this problem by attaching referral information to the bottom of public health posters that outlines what options a woman has when she wants help with an addiction. Public health campaigns have done little to address the stigma that the larger society places on pregnant women who misuse substances.

Recommendation 7: That Manitoba Health ensure that public health posters and health education and information materials include information about where and how services, particularly addiction services, can be accessed by pregnant women.

Pregnant women who abuse substances are one of the most stigmatized groups of people, and are often described by a range of negative labels such as "child abusers" and "criminals." These women are believed by many to be selfish, irresponsible, and undeserving (see also Boyd, 1999). Not only do they carry the stigma of having an addiction, but the stigma of being pregnant while abusing. The image of the anti-mother is clearly pictured in the collective consciousness of mainstream society. No public health messages were found that attempted to address this stigma, except for attempts among Aboriginal groups who situated the public health message within the context of community wellness and the responsibility of all members of the community for the wellness of each individual.

b. Mentor Programs

During the past two years, the Manitoba Child and Youth Secretariat[6] has sponsored two mentor programs to address the prevention of FAS. Both programs are located in Winnipeg, and a third program sponsored and operated by the community of Norway House has been started.[7] These projects are modeled on a program currently operated in Seattle, Washington. Although the "STOP FAS" programs are relatively new, during recent years quasi-mentors have been used by Child and Family Services agencies, as well as public health nurses and outreach workers. The most common mentors have been support workers who go into women's homes to help with infant care, home care responsibilities and child care. Most of the women on social assistance who were interviewed for this project had a support worker at one time or another.

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[6] Following the Manitoba provincial election in 1999, the Secretariat was transferred to Manitoba Family Services and Housing and its programs now come under the Healthy Child Initiative.

[7] The Norway House program was not assessed for this study as it is located on a First Nation reserve.

The degree of involvement a worker has in the life of a woman tends to depend on the type of relationship the woman is able to develop with the worker. In some cases, the woman sees this relationship as very positive, while others view support workers with suspicion, and feel that they are there to spy on them for CFS. In certain situations, some women go as far as to turn down offers from CFS to have support workers come into their homes, fearing that a support worker may give negative reports to CFS that would result in the apprehension of their children. Becoming visible to CFS, according to many women, automatically puts them at risk of having their child(ren) apprehended by the agency (see also Boyd, 1999).

In this study, the women most likely to be suspicious of support workers, whether from CFS or from other agencies, were Aboriginal women and/or women who had been involved with CFS as children. For many Aboriginal women, this suspicion is fueled by the long-term relationship that Aboriginal peoples have had with CFS whereby a disproportionate number of Aboriginal children continue to be removed from the care of their biological mothers (Manitoba Métis Federation, 1999:4; Fourneir and Crey, 1997). Generational involvement with CFS has meant that many Aboriginal women see these agencies as an enemy to avoid, rather than a resource to assist them.

Similarly, women who were in foster care as children viewed CFS as a threat to their families and often avoided any involvement with these agencies. Of the 74 women interviewed, 24 (33%) reported being placed in more than five foster homes during childhood. In one case, a woman reported being in more than 20 different foster homes before she was 18 years old. For these women, memories of moving from foster home to foster home has meant that they will do anything to prevent this from happening to their own children. Women are also aware that foster placement for their children may mean that their children end up living in hotel rooms under the supervision of caregivers who change shifts every few hours. Therefore, a pragmatic strategy employed by some women is to stay out of view from CFS. This means that women not only miss taking advantage of support programs offered by these agencies, but also that this type of response generally is understood by their social workers as non-compliant behaviour or disinterest on the part of the woman to help themselves and their children.

In the experience of the women interviewed, support given by CFS is withdrawn if their children are apprehended. Instead, the woman is given a list of requirements that must be met to regain custody of her children. Going to addiction treatment is generally one of the requirements. According to the women interviewed, as well as many frontline workers, this removal of support comes at a time when the woman most needs the support because of the loss of her child(ren). However, because the welfare of the mother is not the mandate of CFS, she does not warrant any kind of intense intervention, such as help in entering an addiction treatment program. Fortunately, some CFS workers do assist women in accessing addiction treatment. However, this is not always the case because they typically have heavy caseloads that prevent them from lending much assistance to the mother once her children are removed. Any relationship the woman has developed with her children's CFS worker and her support worker tends to be strained during this period, and in many cases, the women turn away from help offered by CFS.

The "STOP FAS" programs are designed to address some of these problems, as well as others that arise for women around substance use during pregnancy. The aim of the program is to give long-term (three years) support to women who are at high risk of having babies affected by alcohol use during pregnancy. The difference between this model and other prevention strategies is that it focuses on the well-being of the mother and her children, rather than just on that of the children. As a result, even if the children are removed from the care of their mother, she remains in the program. The program takes a hands-on approach to helping women access the services they need, and unlike other programs, the woman, rather than the service provider, determines what those needs are.

In order for women to participate in the "STOP FAS" program, they must self-refer to the program. Generally, service providers tell women about the program. However, the women must make contact with the program representatives. Once an intake assessment has been completed, women are matched with mentors who work intensively with them for the next three years. Unlike the mandate of CFS, the "STOP FAS" mandate is focused on the woman as well as her children. This program, according to service providers and consumers, has proven to be very successful in assisting women—including a number of pregnant women—to access addiction treatment. The women involved in these programs are labeled as being at highest risk for having babies who are affected by substance misuse during pregnancy. Even though the program is relatively new, positive outcomes are being reported which are supported by interviews with women who are involved in both Winnipeg "STOP FAS" projects.

In discussions with service providers who provide mentors or support workers to women at risk of misusing substances while pregnant, there is great concern that their prevention efforts are hindered by systemic barriers within the continuum of care. They report that even with extensive support from their programs, women can still have difficulty accessing services that meet their needs. One of the central problems is the lack of communication and flexibility among service providers, particularly concerning the types of programs and services that are available. In many cases, frontline support workers are uncertain what kinds of services other agencies can offer to their clients. In other cases, they can identify appropriate services, but the client is faced with long waiting periods to get into the program, or does not meet one or more of the admission criteria. For example, pregnant women may not be allowed into an addiction program if their due date is before the date they would complete the program, or if they are Hepatitis C-positive. Even the "STOP FAS" program structure, which is designed to help high-risk women, has a formal requirement that women must be misusing alcohol during pregnancy. As a result, women who misuse substances such as inhalants or cocaine, but not alcohol, are ineligible for the program. While some frontline workers have found ways around this formal requirement, the barrier still formally exists. The service providers' fear is that as the programs take on full client loads, they will become more strict thereby excluding certain women from the program, or that women will purposely abuse alcohol to meet the requirements. Evidence of this has already been noted by some of the mentors.

As service providers, mentors play a supportive role in the lives of their clients. However, a fine line exists between professionalism and friendship. In discussion with women who had mentors, particularly those women in the "STOP FAS" program, the women viewed their mentors as their friends more than service providers. From the point of view of the mentors, this was beneficial in that they were more successful in encouraging women to set goals and pursue support services that would address their substance misuse. On the other hand, mentors were concerned that their central role in the lives of their clients could result in women becoming too dependent on the mentor/client relationship, which could create future problems (e.g., if the mentor was to leave the program). Mentors also reported that relationships with a woman's partner and family members could be difficult as their mandate was to work with the woman, and not necessarily members of her support network. For example, many women in this study reported that their partners did not want them to seek addiction treatment. This could potentially place the mentor and women's partner in an adversarial relationship which could be dangerous for the woman and/or the mentor. Mentors reported that there were cases where they did feel uncomfortable or unsafe with their clients' male partners and/or other family members.

KEY RECOMMENDATION 8: That Manitoba Health support the creation of mentor programs similar to the "STOP FAS" program for high-risk women in regions of the province outside Winnipeg, and mentor programs which address other substance addictions, particularly the use of inhalants.

c. Community Wellness

A focus on community wellness is a strategy adopted by some service providers to prevent substance misuse during pregnancy. However, programs that prioritize community wellness tend to be marginalized in relation to initiatives that focus on individual women. Among initiatives that are directed toward community wellness, the majority occurs in Aboriginal communities in both urban and rural areas. These initiatives begin by trying to understand substance misuse as a health and wellness problem that stems from historical and social factors that have negatively affected the well-being of the community. In the belief that a healthy community has healthy members, these strategies focus on the wellness of the whole community, and work alongside programs directed towards individuals.

Concepts such as "community" and "wellness" can vary depending upon the specific definition applied by groups of people. For the purposes of this discussion, they will be defined in relation to substance misuse. "Community wellness" is the absence of harm caused by substance abuse to a group of people who identify themselves as a community. "Harm" includes any negative outcome due to substance abuse within the community, including issues such as chronic poverty, unemployment and underemployment, low life expectancy, violence and abuse, accidental deaths and suicide, and hopelessness and despair. It also includes harm caused by substance misuse during pregnancy. With this said, it should be noted that substance abuse alone does not cause the above outcomes. Rather, substance abuse in a community is intertwined in complex ways with all the other variables to create the reality that exists.

Data from this project found that community wellness or non-wellness impacts significantly on pregnant women. For example, Métis service providers who deal with northern Métis communities pointed out that strategies that target only pregnant women in communities with epidemic rates of alcoholism will not be successful because there is simply not enough support for these women to stop using. Sending women from these communities away for addiction treatment—no matter how supportive or innovative the program may be—is only a bandaid solution for the time they are in treatment. Once they return home, they are placed back in the same dysfunctional social environment as when they left. Setting up programs within the community that specifically target pregnant women will have only limited success if women continue to live in a social environment where everyone in their support network abuses substances. Service providers from all regions of the province reported situations where a lack of community wellness made interventions that specifically target individual women ineffective.

Service providers argued that community wellness initiatives need to work in conjunction with more specialized programming, such as addiction treatment, and that these initiatives must be culturally-sensitive to the communities they target. According to service providers and consumers, it is central to cultural sensitivity that individuals who have similar cultural beliefs to those of their clients provide the services. This is particularly true for homogeneous communities, such as First Nation or Métis communities, or for urban neighborhoods with concentrated ethnic populations. While First Nation reserve communities increasingly influence and control the services delivered on reserve, financial constraints have meant that Métis and off-reserve status and non-status First Nation people lag behind in their ability to deliver culturally-appropriate services. Federal and provincial governments are targeting more resources for these groups, but several barriers exist, particularly for Métis service providers. Métis people are automatically lumped together with First Nation groups because it is assumed they share the same cultural beliefs and practices. While they do have much in common, Métis people in Manitoba have a distinct identity, and when grouped with First Nations, are generally placed in a minority position *vis-à-vis* decision-making and funding. For example, Métis Child and Family Services (the central Métis service provider in Manitoba) lacks adequate funding to provide necessary services for their communities, including resources for service providers to travel to remote communities, create services that reflect Métis culture and identity, and provide long-term programming for community and family wellness.

Recommendation 9: That Manitoba Health support strategies that promote community wellness through outreach programs in communities with widespread substance abuse, and that these strategies include ways in which pregnant women can be supported and encouraged to abstain from substance use.

B. SECONDARY PREVENTION AND EARLY INTERVENTION PROGRAMS

1. Programs for Pregnant Women and Women of Childbearing Age

"Secondary prevention" refers to efforts to slow or stop the progression of problems through early detection and treatment. The setting for early intervention efforts lies not within the specialized addictions treatment sector, but within agencies and institutions that provide health and social and other services to women (Poole 1997:13). Within the continuum of care for pregnant women with substance misuse problems, these services are key to identifying women with problems, disseminating information, providing immediate support and brief therapeutic interventions, and making referrals to addiction treatment programs.

a. Pregnancy Programs

There are a number of pregnancy programs that focus on the general well-being of pregnant women. Both the provincial and federal governments fund these programs, and a few are privately funded. Many operate out of local organizations such as community and family centres, the YWCA, and Friendship Centres. In Winnipeg, a broader range of support programs and services for pregnant women exists, and unlike the programs offered in smaller communities, these programs tend to operate autonomously from one another. Some organizations in Winnipeg are able to provide one-on-one counselling for pregnant women who are having difficulties coping during their pregnancies—a service usually not offered to women in smaller communities. While pregnancy programs do not target only pregnant women with substance misuse problems, they usually try to include an education and support component that addresses this issue.

In general, a pregnancy program offers special group services one day a week, although most programs do have an "open door" structure where women can visit the program outside of meeting times. Some of the programs also provide home visits both pre- and post-partum to give women support in their homes. The majority of these programs provide milk to pregnant women, food at their meetings, parenting classes, nutritional education, information about healthy choices during pregnancy, and general support and information. These programs also will advocate for pregnant women who want to enter an addiction treatment program, or who need help with other life circumstances. Some of the programs identify themselves as being either pro-life or pro-choice.

According to service providers and consumers, pregnancy programs are important support mechanisms in the lives of the women they serve. For many women, these programs are not only a valuable source of information, but also provide opportunities for meaningful interactions with other women and service providers. Women who typically access these services are women on social assistance and/or women under the age of 25.

Despite the benefits they offer, pregnancy programs have a great deal more potential to provide outreach services to pregnant women who misuse substances. However, due to limited funding, many of these programs have not been able to develop such services to the extent that they feel are necessary for the communities they serve. In some cases, programs appear to be duplicating services because different governments, either provincial or federal, fund them.

Residential homes are available to pregnant women. These homes allow women to stay throughout their pregnancies, and in some cases, after the birth of their babies. Some residential homes have transitional housing for women when they leave the main residential home. Typically, adolescent and young adult women access this service, although it is available to all pregnant women. However, the homes are usually not in the position to accommodate pregnant women who have other children in their care. While in the program, women have an opportunity to attend several classes that prepare them for the birth of their babies. As well, some of the younger women are enrolled in school to help them finish their high school education.

For pregnant women who have problems with substance misuse, residential homes provide an alternative to residential addiction treatment. This is particularly true for young women. While these homes do not provide addiction treatment services, they do provide positive supports for women while allowing them to escape social environments that contribute to their substance misuse. The homes typically support women in accessing outpatient/-day addiction treatment services or self-help groups by supplying transportation to meetings and child care services for their newborn babies.

Recommendation 10: That Manitoba Health assist pregnancy outreach programs and residential homes for pregnant women to develop specialized services for pregnant women with problems of substance misuse, including counselling about service options for dealing with substance misuse, referral to addiction services, and aftercare support once a pregnant woman has completed treatment.

Recommendation 11: That Manitoba Health assist residential homes for pregnant women in providing, or in helping women to find, child care services that are safe and accessible during the period of their stay at the home.

b. Community Services for Women

Community services for women vary greatly, with the largest number and variety located in Winnipeg. The range of services includes women's resource centres, shelters, transition housing, youth programs and services, support and self-help groups, and outreach centres. While none of these programs deals only with substance misuse during pregnancy, they typically have clients that experience such problems. The majority of these organizations offer information literature and referral services for those clients who may need addiction treatment and/or support during their pregnancies. Other services provided include parenting classes, food and clothing depots, community gatherings, and counselling. Some organizations accompany women to medical appointments and meetings with their social workers, provide space where women can have visits with children who are in the care of CFS, advocate on behalf of women with other service providers, and provide short- or long-term day care.

For a pregnant woman who has a problem with substance misuse, this group of service providers can be key in supporting her during and after her pregnancy. They are also the group of service providers who may have initial contact with the woman, or in some cases, be the only contact a pregnant woman has with service providers through her entire pregnancy.

Workers who provide special services for women were very concerned that their clients were not able to access the kinds of addiction services that were appropriate to their needs. While they felt that addiction treatment for pregnant women was more accessible than it was a few years ago, they still had problems with the current situation. In their experience, there were not enough addiction services that specifically addressed the needs of women. While many programs had special sessions for women, the service providers pointed out that most addiction programs were initially designed to provide services to male clients. Only recently have special addiction services for women become available in most treatment programs, and many of these still have not fully developed gender-sensitive programs. Instead, counselling group sessions for women are basically the same programs without male participants.

This group of service providers also reported that they did not feel there was enough communication and flexibility among service providers. Many programs and services focused on their specific mandates, and not enough coordination occurred between service providers within the continuum of care for women. This was particularly true in Winnipeg, as smaller centres such as Brandon, Thompson and The Pas were further along in the development of better avenues of communication and cooperation among their various organizations and agencies.

Many of these service providers saw the breakdown in the continuum of care as a major contributor to why many women with substance abuse problems failed to access addiction treatment and aftercare services. One of the major factors is the level of comfort that women have with the services they access combined with the fact that services are located in various places. For example, typically a pregnant woman who accesses a service such as a shelter cannot receive counselling for substance misuse problems. She has to go to another program that deals with addiction treatment. She cannot receive pregnancy information and support at the addiction treatment program and must access that elsewhere. If she is in a residential addiction treatment program, she may not be able to access prenatal support provided by pregnancy programs until after she completes the addiction treatment program. Because most services for women are designed to deal with a specific issue that impacts upon their lives—such as domestic violence, pregnancy, or addiction—they are left to negotiate their way through a maze of service options. This is not always easy, especially for women who are dealing with substance addiction and who may be fearful of the implications of becoming visible to service providers in the first place. As well, women from certain groups, such as First Nation or Métis women, may not feel comfortable accessing services provided by non-Aboriginal service providers and organizations.

Service providers and women pointed out that negotiation of services could be very difficult for pregnant women with substance misuse problems, particularly if the woman had other children in her care. While the experience of women will be discussed in detail later in this report, it is important to examine this from the point of view of service providers. First, the majority of service providers reported that they had difficulty dealing with pregnant clients who were misusing substances. While most service providers tried not to judge the behaviour of these clients and to help them access the types of services they needed, many service providers still could not relate to the behaviour of these pregnant women. Service providers varied in their views on how accountable they felt the woman should be for her actions, and what was the appropriate moral and societal response.

The majority of service providers felt very anxious about pregnant women using substances no matter what they thought the moral and social response should be. How they dealt with this anxiety varied. Some service providers felt obligated to contact CFS because they equated the actions of the woman with child abuse. Others felt that involving the woman in as many support services as possible—prenatal programs, addiction treatment, and/or healing circles—was the answer. Some service providers tried to convince pregnant women either to go to a residential addiction treatment program or to a pregnancy home until their babies were born, while others tried to find ways women could reduce harm to themselves and their fetuses by suggesting, for example, that the women try other, less harmful, substances or reduce their current use.

Several barriers prevented service providers from accomplishing their service goals. These included, but were not limited to, the five examples presented here. First, many service providers felt that their mandate was too narrow, and as a result, their expertise in certain areas was limited. The problem for them was that women do not access their services as fragmented beings; rather, when providing service to women, they are dealing with the whole woman and all her problems simultaneously. Second, reporting a woman's substance use to CFS could jeopardize any trust that has been built between the service provider and the woman, and may result in the woman no longer accessing services from them or any other agency or organization. While not all service providers reported pregnant clients who were using substances to CFS, if the woman did have other children in her care and there were signs that her substance use was putting those children at risk for abuse or neglect, the service provider was legally obligated to report this to CFS. Third, being located in an inappropriate building, such as the same building as CFS, could discourage pregnant women from attending certain programs for fear that they would become visible to CFS. This was particularly true in smaller communities where limited space was available to house programs. Fourth, many service providers reported that they did not have enough staff and funding to deal with the service demand for individual counselling, outreach services, or follow-up programs. Fifth, some service providers reported that their clients were prevented from accessing services because they did not have transportation or child care. Their program budgets did not extend to providing bus tickets, taxi fare or child care services to clients.

Recommendation 12: That Manitoba Health support organizations that provide community services to pregnant women to improve communication and flexibility among such organizations, addiction treatment programs and CFS, so that pregnant women receive comprehensive information about available services that best fit their needs.

c. Place *Versus* Program

A limited number of services for women and their children operate as drop-in and outreach centres. These include services such as women's resource centres, Aboriginal Head Start programs, family centres, and Friendship Centres. The typical way a woman living in the community accesses these services is on a "drop-in" basis, and what makes this type of service unique is that it operates as a *place* rather than a *program*. In other words, women have access to the service without having to attend a program, such as a parenting or prenatal class (although these services are often offered). A good example of such a service is Street Connections in Winnipeg.

Community-based outreach centres such as Street Connections, a service for street-involved women and transgender persons in Winnipeg, begin with the notion of community and build their programs and services from that base. Even though they have limited hours of operation, they are open regularly through the week. Women are encouraged to identify with the service as a place that they can come to and see other women who are experiencing similar life challenges. Places such as these have the capacity to build positive support networks for women and a sense of ownership or belonging in an environment that is non-threatening or judgmental.

Various service providers are available to women at outreach service centres. For example, Street Connections has a nurse on site so that women can access primary health care in a setting where they feel comfortable. They see the same nurse each time they have an examination, and are able to build a level of trust with her. Social workers and counselors who work at the centre mix with clients who come to the house to "hang out." The women who access this service reported that they would often speak with workers at Street

Connections before anyone else about what was happening in their lives because they trusted them to keep their conversations confidential. The women also respected the workers' opinions, and felt that they were non-judgmental and listened to them rather than pushing them into programs and activities in which they did not want to participate. Service providers at Street Connections also made themselves available to accompany women to appointments, and to advocate on behalf of women with other service providers when necessary. However, as with other similar programs, they are constrained by staff shortages and limited financial resources to meet client demand.

An important aspect of this particular program example is the sense of community that women at Street Connection feel for one another. Women reported that since attending Street Connections, they felt a greater connection to other people and were able to gain positive support no matter what was happening in their lives. For them, Street Connections was a place where they could relax, laugh, and talk with others. It broke the isolation and loneliness many of them felt. Street Connections was a way for women to find their way off the streets with the support of service providers who referred them to other services and assisted them in accessing those services. It also served as aftercare or long-term community support which reinforced the positive things that women were doing for themselves and their families.

KEY RECOMMENDATION 13: That Manitoba Health develop the service capacity of gender-sensitive outreach services that women strongly identify as being supportive and trustworthy, particularly those services that deal with specific high-risk populations and in communities with widespread substance abuse. It is further recommended that these services work in conjunction with other agencies, such as addiction treatment programs and Child and Family Services agencies to support women in building healthy support networks, and decreasing or ceasing their use of substances before, during and after pregnancy, creating stable home environments, and expanding their education and employment options.

Recommendation 14: That Manitoba Health recognize the need for, and the benefit to be gained from, services that operate as places rather than locations for the delivery of a defined program. In particular, attention should be paid to the ability of this type of service to support women at high risk for substance misuse during pregnancy in building positive supports that will help them to reduce or cease using substances before, during and after their pregnancies.

Recommendation 15: That Manitoba Health support ways in which the hours of operation for outreach centres can be increased to include evenings and weekends, and increasing the number of staff and the amount of funding available to provide appropriate services and programming for the extended hours.

d. Health Care Providers

During and after pregnancy, women are usually involved with at least one health care provider, typically a general practitioner or obstetrician. The contact that physicians have with pregnant women can be an opportunity for information about pregnancy and substance misuse to be provided, and referral made to addiction treatment programs. However, information collected from women and service providers indicates that physicians are generally not incorporating this approach into the care they provide to pregnant women. While it has become standard practice among most physicians in Manitoba to ask pregnant women if they are using substances, some women reported that they were not asked. For women who did have discussions with their physicians about their use, none were directly referred to an addiction treatment program. Instead, women were either instructed to stop or cut down their use, advised to go to an addiction treatment program, or encouraged to have an abortion. In some cases, particularly among middle-income women, physicians downplayed their use as insignificant even when the woman had serious substance abuse problems. Women felt this was based on the physician's inability to see them as addicted.

The climate in which health care is provided to pregnant women is one in which women are quickly moved through scheduled appointments usually lasting only a few minutes. In the short period of time that a physician generally spends with a pregnant woman during a routine check-up, there is little opportunity to discuss her concerns about substance misuse. In some cases, other medical staff, such as nurses, are in a better position to raise the subject with women. But too often they are held to rigorous schedules that leave little time for individual women.

Community health clinics, such as Mount Carmel Clinic and Klinic, are important sites where pregnant women are receiving information about substance use during pregnancy from both physicians and other health care providers. This appears to be especially true for younger women. Health care providers in clinics such as these deal with women who are typically at high risk for substance misuse problems, and therefore, have prepared themselves to deal with the wide range of related health issues these women have.

Public health nurses are a third group of health care providers that see pregnant women. They offer services in all geographical regions of Manitoba and have the majority of contacts with some women, particularly women in isolated communities both pre- and post-partum. Public health nurses provide services in clinical settings or through home visits. They have also been involved in community education initiatives, and have coordinated with other service providers in delivering prenatal services for women.

Midwives are a fourth group of health care providers who are particularly important because of the close relationship they have with pregnant women. While limited information was collected about midwifery for this study, there appears to be potential for midwives to play a central role in supporting pregnant women who are struggling with substance addiction.

Recommendation 16: That Manitoba Health recognize that health care providers are in a key position to identify pregnant women who are at risk for abusing substances, particularly women who are less visible to other services providers. It is further recommended that health care providers be required to refer pregnant women who are misusing substances to appropriate services, and to follow-up with the women in subsequent appointments.

Recommendation 17: That Manitoba Health support the key role of public health nurses to provide support services to pregnant women who misuse substances, particularly in high-risk geographical areas.

Recommendation 18: That Manitoba Health support the hiring of more public health nurses of Aboriginal descent to work in high-risk areas where Aboriginal women comprise a large portion of the client population.

Recommendation 19: That Manitoba Health explore ways in which midwives could work as frontline service providers for pregnant women with substance abuse problems.

e. Child and Family Services

Child and Family Services agencies operate in all geographical regions of the province. The Manitoba Government is responsible for funding and setting standards for these agencies. Some CFS agencies address the needs of specific groups and communities, such as the First Nation CFS agencies and Métis CFS.[8] The general mandate of CFS agencies is to protect children from neglect, abuse and exploitation. Within this mandate, the agencies provide and support various family programs, and manage foster care and adoption of children who they take into care. Typically, CFS deals only with women and families who are on social assistance. Without exception, CFS is the most influential service provider in the lives of the clients they serve.

In recent years, CFS agencies have become concerned with substance misuse during pregnancy. In 1997, the Supreme Court of Canada determined that a pregnant woman could not be legally detained against her will (including being mandated into addiction treatment) to protect her unborn child from conduct that might harm the fetus. The decision was based on several factors, including:

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[8] Métis Child and Family Services, during the time of this study, had a limited mandate to operate as an advocacy service for Métis women and their families.

- the fetus is not recognized as a person until born alive under Canadian law;
- considering the interests of the fetus separately from those of the woman ignores the woman's fundamental human rights to bodily integrity, equality, privacy and dignity;
- considering the interests of the fetus separately from the woman has the potential to create adversarial situations in the woman's relationships with her partner and physician;
- such a law could hold a woman liable for any behaviour during pregnancy that could potentially effect her fetus adversely, such as failing to eat properly, using prescription drugs, smoking, or being exposed to workplace hazards;
- the women most likely to be affected by such a ruling would be women who were visible because they were socio-economically disadvantaged;
- such a law fails to acknowledge that substance abuse by some pregnant women is the product of circumstances and illness rather than an uncomplicated choice to use or not use;
- women do not abuse substances because they do not care about their fetuses; a product of addiction is the inability to control intake of the substance being abused. Laws which would mandate women into treatment would fail to recognize the range of conditions that contribute to addiction, and would result in some pregnant women avoiding prenatal care and other types of support for fear of being detained. However, as with some other service providers, many CFS workers currently equate substance misuse during pregnancy with child abuse, and have created ways in which they can coerce pregnant women to enter addiction treatment without basing their reasons on the health of the fetus.

Currently, the response by many CFS agencies, particularly those in Winnipeg, is to notify pregnant women that they know are misusing substances that a "birth alert" or apprehension order has been placed on the babies they are expecting. This order basically means that upon the birth of the baby, CFS will remove the infant from the care of the mother. In these situations, women are strongly advised to enter an addiction treatment program to protect their unborn children and to demonstrate a commitment to the agency that they have the well-being of their babies in mind at all times. If the woman enters an addiction treatment program and subsequently completes it, the agency agrees to take this into consideration when determining whether the woman is fit to parent her newborn infant. If the woman does not enter treatment or fails to complete a treatment program, it is most likely that the baby will be apprehended at birth and placed in the care of a foster family. If the woman has other children in her care, they will be apprehended when the "birth alert" is placed on the woman, and will only be returned to her if she completes a treatment program. In some cases, children are returned to a woman earlier if she attends a program that will accommodate the children of the clients they serve. CFS workers generally require pregnant women to go to a long-term treatment program, and expect them to stay until the birth of their babies. In most cases, they require that the woman return to treatment with her newborn baby and stay there until CFS determines that she has control over her substance abuse problem and that she is capable of parenting her child(ren).

According to service providers and consumers, this ultimatum usually is enough to "motivate" women to seek addiction treatment. Since the Government of Manitoba has encouraged addiction services to prioritize pregnant women for treatment, they are usually successful in being admitted into a treatment program in a relatively short period of time (about one week).

Findings from this study found that placement of "birth alerts" were inconsistent throughout the province. It was likelier that women in Winnipeg would have a "birth alert" placed on them. According to social workers, placing a "birth alert" is not the best response to a situation where a pregnant woman is abusing substances. However, given excessive caseloads and limited resources, it is the best of only a few options available to CFS workers. CFS workers echoed similar concerns as other service providers about the need for better communication and flexibility among service providers. They were also very supportive of services, such as the "STOP FAS" mentor program, that were able to work with pregnant women once a "birth alert" was placed.

Other service providers voiced mixed feelings about the use of "birth alerts" to motivate pregnant women to enter addiction treatment. For addiction experts, this type of practice means that women are not only coerced into treatment, but that they are also anxious about the outcome of the alert during treatment.

Generally, the use of "birth alerts" is a punitive sanction used to motivate women into addiction treatment. Despite the anxiety that many service providers feel when they have knowledge that a pregnant client is misusing substances, this study found that this type of "motivation" is understood by women as force or coercion which can result in some women not going to treatment and instead trying to hide from CFS, or in women dropping out of treatment because they do not feel invested in the program they are attending. This study also found that apprehension of a pregnant woman's other children to "motivate" her to go to addiction treatment is a risk factor for increased substance misuse once the children are gone.

First Nations in Manitoba have successfully argued that they should have full control over Child and Family Servicess for their reserve communities. Similarly, Métis communities have argued the same for their people. In a recent publication, the Manitoba Métis Federation outlined its current position on Métis children and families, stating that a disproportionate number of Métis children are taken into care each year, the majority of whom are placed in non-Aboriginal foster and adoptive homes (1999:4). Only limited resources for Métis Child and Family Services are available to assist Métis families in regaining custody of their children, despite Métis people identifying strongly with this service. The result has been devastating in many cases for children, parents, and communities who find themselves losing significant numbers of their children. This has contributed to increased substance abuse by community members, including pregnant women.

CFS social workers felt that they were less successful in delivering services to Aboriginal women, partially because of cultural differences between non-Aboriginal social workers and Aboriginal clients, and the influence of other factors such as poverty. Aboriginal clients were typically the poorest of the poor, and had social workers that were typically middle class. For both social workers and clients, these differences could create feelings of distrust, frustration and misunderstanding, and could contribute to Aboriginal women not accessing available services.

KEY RECOMMENDATION 20: That Manitoba Health recognize that Aboriginal agencies, such as Métis Child and Family Services, Friendship Centres, and the Aboriginal Health and Wellness Centre in Winnipeg are in key positions to work directly with high-risk pregnant women and communities which they serve under their current mandates, and are in the best position to create meaningful programs and services for Aboriginal women and to work with Aboriginal off- and on-reserve addiction services.

Recommendation 21: That Manitoba Health, in conjunction with CFS, encourage the hiring and training of more Aboriginal social workers to work with high-risk pregnant women.

f. Poverty and Service Delivery

Both primary and secondary prevention service providers felt that providing more addiction services was secondary to dealing with larger issues such as chronic poverty, low levels of education, high unemployment, violence and abuse, and mass substance abuse that exists in the social environments in which the majority of their clients live. Many workers believed that until these issues were addressed seriously, women would continue to move in and out of addiction treatment programs with little long-term success. This was supported by information gained from women who reported that their social environment was a key contributor to their substance misuse and to their periods of relapse.

C. DETOXIFICATION AND TREATMENT PROGRAMS

Addiction treatment services are offered by number of programs throughout the province. For the purposes of this project, "treatment" refers to the broad range of services including identification, brief intervention, assessment, diagnosis, counselling, medical services, psychiatric services, psychological services, social services, and follow-up for persons with alcohol- and other drug-related problems. The overall goal of treatment is to reduce or eliminate the use of alcohol and other drugs as contributing factors to physical, psychological and social dysfunction and to arrest, retard, or reverse the process of any associated problem"(Poole 1997: 16).

The largest addiction treatment service agency in Manitoba is the Addictions Foundation of Manitoba (AFM), a provincial crown agency. The AFM's services include residential and non-residential treatment programs in almost every region of the province. The AFM operates programs specifically for women: the central service is a short-term (28-day) residential treatment program located in Winnipeg. A number of other addiction treatment services exist in the province for women, the majority of which are in or around Winnipeg. The remaining programs are mainly located in First Nation communities and are only accessible to Aboriginal clients, or are services provided by the AFM.

In 1999, Manitoba had nine residential and non-residential addiction treatment programs specifically for women (Roberts & Ogborne 1999:20). Several other mixed-gender (for men and women) addiction treatment programs offered special services for women, usually in the form of individual and/or group counselling. Pregnant women are admitted to all addiction services open to women, but in some cases, they are only admitted if they have time within their pregnancies to complete the program. In other cases, pregnant women who may have medical complications or whose pregnancy may be considered high-risk will not be admitted to residential treatment programs. Addiction treatment services that have pregnant women participating in their programs do not usually include special services for pregnant women, such as prenatal care, nutrition programs, and parenting classes. Women reported that the birth of their babies was a strong motivation to decrease or cease using substances, but residential programs do not allow women to bring their children (including their newborn babies) with them to treatment. Outpatient/day programs typically do not provide child care. In some programs, whole families are admitted into treatment.

Addiction treatment services specifically for women decrease as one moves outside of Winnipeg. In some cases, addiction workers located in central urban communities cover a wide geographical region that limits the time that they can spend with individual clients and treatment groups. In other cases, women do not have access to female counselors in the region they live. Even among the addiction treatment services for women in Winnipeg, many programs have long waiting lists—in some cases up to a year or more. While the majority of treatment programs have prioritized pregnant women for admission, this study found that women typically access addiction treatment when they are not pregnant.

1. Detoxification and Outpatient Withdrawal Units

Detoxification and outpatient withdrawal units exist in some parts of the province, but in most areas, services are limited or do not exist. The mandate of detoxification programs is to provide a safe place for individuals to withdraw from the physical effects of varying substances. In 1999, Manitoba had 40 detoxification beds, 15 of which were allocated to female clients (Roberts & Ogborne 1999:7). Despite beds being set aside for female clients, no detoxification and outpatient withdrawal units specifically for women exist in Manitoba.

According to addiction service providers, many of the women who access addiction treatment services do not go to detoxification or outpatient withdrawal services first. While not all individuals who enter addiction treatment programs require withdrawal services, of the ones who do, many may not access the service because it is simply unavailable. Primary medical detoxification services are offered by local hospitals, but some are reluctant to set aside beds for individuals that need withdrawal services. In some communities, addiction service providers have advocated for more beds, but hospital administrators and staff have been reluctant to do so.

Secondary detoxification units that women can access exist outside of hospitals, are located at the Main Street Project and the Primary Care Unit at the AFM in Winnipeg. The Main Street Project offers an emergency shelter for both intoxicated men and women. The Project also admits individuals who police have taken into custody under *The Intoxicated Detention Persons Act*.[9] After intake, these clients can choose to move into the detoxification unit to withdraw. Similarly, the AFM's Primary Care Unit offers services for clients to withdraw from alcohol or drug use. However, the Unit does not accept clients brought in by police. The length of stay in withdrawal is usually around four or five days, but can be longer depending on the person's condition. Following withdrawal, AFM clients are referred to the other addiction services both in-house and out.

Data from this project suggest a gap in services for pregnant women who are taken into custody by police under *The Intoxicated Persons Detention Act*. While pregnant women in Winnipeg are taken to the Main Street Project where they are given the opportunity to be referred to other addiction treatment services, in other parts of the province pregnant women taken into police custody are placed in a drunk tank for a few hours and then released. Because there are no addiction services for women that accept clients who are intoxicated, the police have no place to keep these women except in jail cells. The police do not normally offer any type of counselling that could encourage pregnant women to seek out the services, or to refer them to such services.

Lack of shelter for intoxicated women is a problem in all parts of the province. Shelters for women operate, for the most part, with a zero tolerance policy because they are not equipped to deal with intoxicated clients. The emergency shelter at the Main Street Project does offer shelter to these women, and serves as a safety net when all other services have refused to take a client.

KEY RECOMMENDATION 22: That Manitoba Health develop services for pregnant women who present for services when intoxicated, including women who are detained by police under *The Intoxicated Persons Detention Act*.

Recommendation 23: That Manitoba Health ensure that hospitals throughout the province work closely with addiction service providers to ensure that easily-accessible detoxification and withdrawal services are available to women in as many regions of Manitoba as possible.

Recommendation 24: That Manitoba Health ensure that detoxification and withdrawal services are sensitive to the specific needs of women, particularly pregnant women, and that these services assist pregnant women in finding appropriate addiction services upon discharge from detoxification units.

2. Outpatient and Day Treatment

There are several outpatient addiction treatment programs that provide services to clients who live at home. In 1999, Manitoba had 12 outpatient treatment programs and five day/evening treatment programs. These programs offer addiction treatment in the form of group or individual counselling sessions. In some cases, outpatient or day clients attend residential treatment centres and participate in the same treatment activities as residential clients. Outpatient and day treatment programs are either short- or long-term. Some are a prerequisite for residential treatment, and/or provide immediate treatment for people who are on waiting lists for residential treatment.

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[9] *The Intoxicated Person Detention Act* permits police to take into custody individuals who are intoxicated and may present a danger to themselves or others.

Outpatient/day treatment programs vary in their treatment modalities. Typically, programs that offer gender-specific treatment have long waiting lists (in some cases, women have had to wait up to a year or more to access the program they want). For example, the Laurel Centre in Winnipeg offers outpatient-counselling services for "women who have experienced childhood or adolescent sexual victimization and want to resolve long-term effects of the abuse." The uniqueness of this program has drawn many women, and the Centre has a current waiting period of a year and a half. In the past, the Centre has offered a short-term program for women on the waiting list, but the approach resulted in women revealing very sensitive issues only to be stopped short in their treatment and put back on the waiting list until a space became available. Addiction workers argue that the best time to provide services to women with substance misuse problems is when they are ready to address the issue. Long waiting lists result in women falling through the cracks because their attempts at accessing treatment are unsuccessful. Long waiting lists are a strong indication that women believe the service is one they want and are committed to entering.

Outpatient/day programs allow women to stay at home with their families while attending treatment. Service providers stated that women with supportive social networks were more successful in these programs than women who lived in social environments where everyone around them was using. This type of service was also important for women in communities where a residential program did not exist, in that women were not required to leave their communities for treatment. This was particularly important for pregnant women who did not want to leave their homes.

Outpatient/day programs, particularly in Winnipeg, allow women more confidentiality when accessing addiction treatment than do residential programs because they often offer individual counselling, and allow women to return home after each session. This was less true in smaller urban and rural centres where for both residential and outpatient/day programs, people in the community were very aware of who was attending. Outpatient/day programs appear to appeal to women from differing socio-economic groups more than residential programs that typically draw women from disadvantaged socio-economic groups.

A drawback of outpatient/day programs for pregnant women is that women, while attending treatment, still have the responsibility of childcare, attending prenatal appointments, negotiating their relationships with partners and family members, and dealing with employers or social workers. Attending to these other responsibilities can be difficult when women are in a treatment program that requires regular daily attendance. Service providers pointed out that in some cases, women were overwhelmed by the commitments they had while in treatment. Service providers from outpatient/day programs also reported barriers for their clients, such as lack of transportation to and from programs, and available and affordable child care.

Among outpatient treatment services are two methadone programs in Winnipeg, which assist opiate-addicted clients to reduce their substance use through methadone maintenance treatment. Methadone maintenance allows for legal, orally-administered methadone to be prescribed to clients. Clients are allowed access to the program once they have gone through an assessment to determine that they will comply with the rules of the program. Individual counselling is also part of the program, and clients are encouraged to attend self-help/support groups. Women are admitted to these programs, but pregnant women generally are referred to other addiction services. Women who are involved in the program and become pregnant remain in the program during their pregnancies.

Recommendation 25: That Manitoba Health, in conjunction with service providers, find ways to help women develop strong support networks to rely upon during pregnancy, including more outreach and drop-in centres for women, programming directed toward family and community wellness, and recognition of high-risk situations, such as the apprehension of children that may place pregnant women at increased risk for substance misuse.

Recommendation 26: That Manitoba Health assist programs for women with long waiting lists by finding ways to meet service demands, including expanded services in current locations or multiple sites, increased trained staff, and financial resources for appropriate outreach and aftercare services.

Recommendation 27: That Manitoba Health increase the number of outpatient/day programs offered to women, particularly in areas of the province where it is difficult for pregnant women to access addiction services.

Recommendation 28: That Manitoba Health, in conjunction with addiction service providers, find ways to make accessing addiction treatment programs as confidential as possible for women, particularly pregnant women.

Recommendation 29: That when considering the budgetary needs of addiction programs, Manitoba Health recognize that funds for child care and transportation services are essential in removing the barriers women face when accessing treatment.

3. Residential Treatment

Several residential addiction treatment programs exist in Manitoba, and can be found in all regions of the province. In 1999, Manitoba had eight short-term and ten long-term residential addiction treatment programs. Forty-two short-term beds and 78 long-term beds were allocated to women out of a total of 458 (Roberts & Ogborne 1999:7 & 8). In residential addiction treatment centres that are gender-mixed, women make up considerably less of the client population than do men.

Residential services specifically for women are offered by the AFM at River House in Winnipeg. This program has 12 beds and offers a 28-day program that includes group and individual counselling. No accommodation exists at River House for women to bring their children with them into treatment. The Salvation Army Women's Services/Anchorage Rehabilitation Program offers services to women with crisis and relocation issues, and mixed-gender addiction treatment. A number of mixed-gender residential treatment programs offer special services for women within their larger treatment structure, such as AFM residential treatment centres, the Native Addictions Council of Manitoba, and the St. Norbert Foundation. Other residential services specifically for women are located in First Nation communities, but are not discussed here because this project focused on off-reserve services for Aboriginal women.

Women usually enter residential addiction treatment centres through a referral from a service provider in their community. However, some women self-refer, particularly if they have accessed the program in the past. Residential treatment programs are based on either short-term (approximately 28 days) or long-term (usually between 28 days to a year) treatment. Some programs offer special services for women, including group sessions and individual counselling. In the majority of cases, pregnant women are given admission priority, and typically, they enter the program as soon as a bed can be made available (usually in less than a week). However, if they are in the later stages of pregnancy, they many not be admitted if they do not have enough time to complete the program before giving birth.

Some residential programs allow women to bring their children with them. During the day, children are placed in day care or school while the woman is in treatment or attends to other responsibilities that are required by the program. The number of programs that can accommodate children is very limited, and women are left to either place their children in foster care with CFS, leave children with friends or relatives, or decline treatment.

Residential programs in Manitoba use various treatment and counselling strategies. These include life skills programs, self-help and empowerment approaches, behavioural therapies, harm reduction approaches, therapeutic communities, gender-sensitive treatment, and relapse prevention. Treatment models used in First Nation treatment centres are typically based on traditional methods of healing, including the Medicine Wheel and holistic healing, combined with other complementary treatment modalities. In most cases, treatment centres adapt one or more approaches for various aspects of treatment. Other residential treatment centres offer transitional programs, such as Kia Zan Inc. in Winnipeg, which are attended by clients who have completed short-term residential addiction treatment and are making the transition back into their home environments.

4. Aftercare

The large majority of addiction treatment programs offer some form of aftercare programs that assists clients in making the transition from treatment back into their communities. These programs usually consist of several meetings—either group or individuals sessions—where the client returns to the treatment centre for follow-up counselling. Aftercare can be short- or long-term depending on the organization. If the client does not live in the same location as the treatment centre, aftercare programs may be arranged with an agency that provides addiction treatment in the region where the person lives.

In aftercare programs, it is up to the client to make the effort to attend program activities. This can be difficult for women who have children, because the programs do not usually offer child care services. If the program is located far away from where the client lives, even if it is in the same city, transportation problems can become a barrier for some women to access services. In the last few years, some programs have been trying to expand their aftercare services, and have developed outreach services for clients who have not returned for aftercare upon completion of their treatment programs.

5. Self-help and Support Groups

There are several self-help and support groups that address the needs of individuals with addiction. The most well known program is AA, but there are several other groups that address other addictions. Typically, these groups are gender-mixed, with men outnumbering women. A few groups specifically for women do exist, but they are usually available only in Winnipeg. Self-help and support groups are instrumental in providing avenues for individuals to address their substance misuse and recovery. They also provide awareness about the nature of alcohol and drug misuse, support people before and after addiction treatment, and provide long-term community support.

The lay self-help movement plays a significant role in the continuum of care for women with substance misuse problems. This is particularly true in Winnipeg where the largest number of groups exists. Fewer self-help and support groups exist in other regions of the province, and they do not always operate on a regular basis in some communities. A limited number of these groups allow women to bring their children to sessions, but the children have to remain with the woman in the meeting. The majority of groups do not allow children to attend the meetings, nor are they able to provide child care services.

PART 3: THE WOMEN'S EXPERIENCES

A central goal of this project was to speak to women—particularly pregnant women—about their struggle with substance misuse to gain a collective understanding of the experiences women have in accessing addiction treatment and related services in Manitoba. This research strategy is based on the belief that individuals who are targeted for services are in a unique and important position to provide feedback about current gaps and barriers in service delivery. This has the potential to create policy, programming and services that better address their needs within the continuum of care.

This project also attempted to move away from the tendency to focus on the health of the fetus and ways in which birth outcomes can be improved upon when creating programs and services that address substance misuse during pregnancy. This is not to suggest that the health of the fetus is not important in this discussion, but rather to stress that substance misuse is a serious health and wellness issue for women whether they are pregnant or not. For women who struggle with substance misuse, this battle rarely begins or ends because they become pregnant, nor does it generally end with the birth of their babies. Whether this type of behaviour is understood as an illness, a coping mechanism, free choice, or deviant behaviour, in Manitoba, women with addictions or substance misuse problems are generally much less healthy than the average Canadian woman. In many cases, according to service providers and women, long-term substance misuse is an indicator of shorter lifespan and poor overall quality of life. Data from this project suggest that once pregnant, women who struggle with substance misuse tend to become healthier through various means, such as improving their nutrition, taking prenatal vitamins, sleeping more, switching to less harmful substances, and/or decreasing their substance use. The data also suggest that women are more willing to participate in addiction treatment programs to improve their own well-being and to increase their chances of a having a healthy pregnancy if they are approached by service providers who are supportive and non-judgmental. This suggests that pregnancy can be a window of opportunity to improve the health of women with substance misuse problems, while simultaneously improving birth outcomes.

Recommendation 30: That Manitoba Health, in conjunction with addiction treatment services, educate a wide range of service providers about the realities of struggling with an addiction and the difficulties pregnant women can face when trying to reduce or stop using substances.

A. PROFILE OF THE WOMEN INTERVIEWED

The collective experience of 74 women is examined using a health determinants model. By looking at addiction programs, specifically why women enter treatment, the barriers that stand in their way, and their experiences in treatment programs, this section will analyze various factors that contribute to substance misuse during pregnancy. Findings from interviews with consumers suggest that the reasons why pregnant women misuse substances is anything but an uncomplicated choice to use or not use. The data illustrate that when accessing programs and services, women are very pragmatic (see Lock & Kaufert, 1998). However, this pragmatism is not always recognized or understood by service providers because they do not always comprehend the range of contributing factors a woman considers when deciding to access a services. For example, some women chose not to seek prenatal care or help for their substance misuse before giving birth. Most service providers consider this irresponsible behaviour as the women may be putting the health of her unborn child at risk. But from the point of view of the woman, seeking prenatal care or addiction treatment increases the risk of having her infant apprehended at birth. By not becoming visible to service providers, the woman may feel that she has a longer period of time to get her substance misuse under control and to find ways to prevent her baby from being apprehended.

Throughout this section, the reasons why pregnant women misuse substances will be explored in relation to the pragmatism expressed by women who were interviewed. By taking this type of approach, the experiences of women can be understood within the broader context of their life circumstances. By situating addiction treatment within the broader context of women's lives, policy and programming that better addresses the service needs of the target group can be recommended

The women who participated in this project were interviewed in three locations: Winnipeg, Thompson, and The Pas. In their collective experience, participants had lived in the majority of the geographical regions of Manitoba, and were able to give information that reflected this experience. While the project had 74 consumer participants, it should be understood that these participants do not represent "'the experience of pregnant women with substance misuse problems in Manitoba." For example, women from disadvantaged socio-economic circumstances were over-represented in the sample population, as were Aboriginal women. On the other hand, women from advantaged socio-economic groups and certain ethnic minority communities (where there is greater silence about substance addiction among women) were under-represented. Despite these limitations, the collective profile of the women that emerged from the data reveals important information about the service needs of pregnant women with substance misuse problems. While there is no single easy solution to this question, the data indicate that there are ways in which more can be done to address their needs.

1. Socio-economic Status

Data from this project suggest that women across socio-economic levels have problems with substance misuse during pregnancy. However, the experiences of women with different social status and income levels vary greatly. This is particularly evident in relation to those women who receive social assistance and those who do not. Women who receive social assistance are far likelier to be visible to service providers and to be targeted for services and programs that address pregnancy and substance misuse, particularly Aboriginal women. With the exception of public health messages that target women in general, women who do not receive social assistance are less visible to service providers, and generally remain outside of the mandate of most government social services and programs that address substance misuse during pregnancy. This is due to the perception of many service providers and government ministries that substance misuse during pregnancy is mainly a problem of poor women receiving social assistance. Service providers and government ministries view employment and higher social status as strong indicators that a woman is not having problems with substance misuse or addiction.

a. Employment

TABLE 1: PARTICIPANTS' EMPLOYMENT STATUS	**Winnipeg**	**Thompson**	**The Pas**	**Total**
Employed	5 (12%)	1 (5.5%)	4 (26%)	**10** **(14%)**
Social assistance	17 (41%)	8 (44%)	5 (33%)	**30** **(41%)**
Student Assistance*	9 (22%)	2 (11%)	0	**11** **(15%)**
Student	1 (2.5%)	1 (5.5%)	1 (7%)	**3** **(4%)**
Homemaker (partner employed)	1 (2.5%)	3 (17%)	1 (7%)	**5** **(6%)**
CFS ward	1 (2.5%)	0	0	**1** **(1%)**
No income	1* (2.5%) **	0	1** (7%) ***	**2** **(3%)**
Unknown	0	0	1 (7%)	**1** **(1%)**
In addiction treatment	6 (15%)	3 (17%)	2 (13%)	**11** **(15%)**
Total	**41**	**18**	**15**	**74**

*Women who are identified as "Student Assistance" were receiving financial support through programs that targeted women on social assistance who wanted to improve their educations.
**This participant had been cut off social assistance because she was in jail. Upon release, she did not qualify for social assistance.
***This participant was living with her parents and had no income of her own.

The majority of women were receiving some form of social assistance. Of the other consumers interviewed, ten were currently employed, and five had partners who were employed. In general, these women were better off financially.

b. Income

TABLE 2: PARTICIPANTS' ANNUAL INCOME LEVELS	Winnipeg (N=41)	Thompson (N=18)	The Pas (N=15)	Total (N=74)
Under $10,000	29 (71%)	6 (33%)	3 (20%)	28 (51%)
$10,000 - $15,000	6 (15%)	6 (33%)	5 (33%)	17 (23%)
$15,000 - $20,000	1 (2%)	0	2 (13%)	3 (4%)
$20,000 - $25,000	5 (12%)	2 (11%)	3 (20%)	10 (14%)
$25,000 - $30,000	0	3 (17%)	1 (7%)	4 (5%)
$30,000 - $35,000	0	1 (6%)	1 (7%)	2 (3%)

Only five women reported an annual household income of over $25,000. Most who reported earning over $25,000 per year were living in two-income homes, or living with partners who were making more than $25,000 per year.

c. The Impact of Poverty

Of the 74 consumers interviewed, the majority lived in extreme poverty, particularly those women in the Winnipeg group. For example. 23 women of the 41 women interviewed in Winnipeg reported incomes below $10,000 per year, with no woman reporting an income above $25,000 per year. Women in the two northern communities of Thompson and The Pas reported higher incomes on average; but the majority of these women still reported yearly incomes under $20,000. Overall, 74% of the women interviewed had incomes less than $15,000.00 per year.

The impact of poverty on the lives of the women was enormous, affecting not only their well-being but also that of their children. The poorer women in the study were typically single mothers receiving social assistance. Some women were working in low-income jobs that still kept them well below the poverty line. The poorest women were Aboriginal. For women living in poverty, daily life consisted of dealing with ongoing problems such as finding enough money for food, transportation, shelter, and clothing. Chronic poverty contributed significantly to feelings of helplessness and hopelessness, and contributed to women choosing to participate in illegal activities such as prostitution, theft, and drug-dealing—activities that are intertwined with, and often promote, substance misuse. One participant explained:

> Most of the time when you're depressed you know there's no money behind you. You have no family to go to. You can hang onto your friends for only so long. You always end up screwing up. You always end up going back [to the streets].

While women who chose to participate in illegal activities saw their decision as a pragmatic strategy to care for their families, this behaviour was viewed by many service providers as irresponsible and unacceptable. Service providers generally saw this type of behaviour as a deficiency in a woman's character, and as harmful to her children (see also Swift, 1995; Boyd, 1999). This view was even more pronounced if the woman was pregnant. For some of the women, illegal activities were often the only viable option available because money from social assistance or from low-paying jobs was not enough to meet the needs of their families. One woman stated:

> Well, it's harder to look your newborn in the face when you're high on crack than it is to look at your big fat stomach. It's the truth. Once my first daughter was born I cleaned up for awhile. For about a year 'til she was about a year old and then I fell back into it again. Because I was on welfare, no money hardly to feed my daughter, I had to turn back to the streets. And there again I'd link up with those old friends, those old habits. You need to numb yourself out to do that.

A second woman explained:

> And they [CFS] had this thing about me working the streets. I'm sorry if I'm not getting child tax or things like that, I'm going to provide for my family. And the only way I know how is that [working the streets], that's the only way I know how to make money because this is how I was raised. I raised myself to know how to survive on the streets. Like it wasn't for my pleasure and it wasn't for money. It was for my kids…

Women reported that participating in illegal activities had both positive and negative outcomes. On the one hand, it meant that some women could break their dependence on social assistance and have a better chance of being invisible to CFS. This was particularly important if they had previous "birth alerts" placed on them, or had had their children apprehended in the past. In other cases, women reported that if service providers found out about their participation in illegal activities, they were automatically labeled as "bad mothers" and risked having a "birth alert" placed on them, or having their children apprehended. One women stated:

> There was nothing really to help me. I was basically labeled "the drug-addicted prostitute." That was it. Once they [CFS, doctors, and counselors] found out the prostitution part and how old I was, it was like, "Oh well, you're a lost case already."

Another woman discussed how, when she was pregnant, she approached CFS to care for her children while she went to treatment. Her children were apprehended once CFS found out that she had been involved in illegal activities and needed help for an addiction. By making herself visible, she became vulnerable to losing her children. She reported that this contributed to her leaving treatment early as she was afraid CFS would not return her children to her care:

> Right away they wanted to take the kids and that. And I said, "Well, if you can help me out I'll try and quit. Like I don't want to be a cocaine addict, a prostitute or a pusher or a drug addict all my life. I want to change." They [CFS] said, "Okay, you try and do it. You go to rehab and that and if you don't pull it off, bang [we will keep the children]." So already you have this big stress.

While substance misuse and poverty became a vicious cycle for many women, it also meant that it was extremely difficult to improve their quality of life, especially if a woman had young children. Many of the women reported that they had little in their daily lives that made them feel that the future would be better for them and their children.

> It's a question too, if you know you are on welfare or whatever and you have all this time on your hands...um...it's just depressing. You feel like you're never going to get anywhere and it's real easy to give up.

In contrast to women receiving social assistance, women living in poverty who were employed or whose partners were employed, were invisible to service providers. Even though these women were dealing with similar significant financial challenges, the involvement of the state in their lives, as well as programs that targeted their specific needs, was significantly less. This was evident in discussions with women who had gone from receiving social assistance to working in low-paying jobs. Once these women became employed, they lost the support they had been receiving from social assistance, such as home support workers. Many programs and services that they would still be eligible to access—such as addiction treatment—remained outside their grasp because they could not afford to take time off work to attend, or could not afford babysitters for their children. In many cases, these women were single parents and were responsible for generating income for the whole family, including unemployed partners. This, coupled with the stigma of addiction, meant that many of the women who were employed were reluctant to seek help for their addiction problems for fear of losing their jobs.

Although poverty is a central factor in the women's narratives as to why they used substances while pregnant, it must be emphasized that poverty alone was not an indicator for substance misuse by women (see also British Columbia Ministry of Children and Families 1998:40). Some women reported that their substance misuse led to them become increasingly disadvantaged socio-economically, in some cases to the point of homelessness. This was due to marriage breakups, loss of employment, or severed ties with family members. Women who had higher household incomes reported that their social status contributed to silence about substance misuse during pregnancy among their families and friends. They stated that it was very difficult for women in middle-income families to admit they had an addiction due to the stigma this would bring to them and their families. Women who were financially better off and who had higher levels of education were less likely to access addiction treatment services than poorer women or women with lower levels of education. This was reflected in many treatment programs where programming was aimed at individuals who were unemployed and who had less than a grade 12 education. Aboriginal women were likelier to access addiction treatment than non-Aboriginal women, which is reflected in the over-representation of Aboriginal women in this study and supported by interviews with service providers.

Women who were financially better off were less fearful of CFS using their substance misuse as a way to gain custody of their children than they were of family members—particularly husbands—trying to gain custody. Some women reported that they were afraid to enter addiction treatment because their ex-husbands could use this against them. In two cases, women had lost custody of their children to ex-husbands, and because they felt they were labeled as "addicts" or "alcoholics," feared they had little chance of regaining custody even though they were no longer using. In one particular case, an ex-husband had used their child's diagnosis of FAS as a way to discredit the women in a legal battle over custody.

Recommendation 31: That Manitoba Health recognize that poverty and related factors play a central role in why some women misuse substances during pregnancy, and that services directed toward women need to address ways in which women can be meaningfully supported to improve their everyday life circumstances. These include, but are not limited to, improving access to education and employment opportunities, and ensuring that women and their children are safe and secure in their homes, neighbourhoods and communities.

Recommendation 32: That Manitoba Health recognize that women in all socio-economic groups are at risk of misusing substances while pregnant, and consider conducting further research specifically targeting middle- and upper-income women to determine the extent of substance use during pregnancy among this group and ways in which these women deal with their substance misuse.

2. Age Cohorts

TABLE 3: PARTICIPANTS' AGES	**Winnipeg**	**Thompson**	**The Pas**	**Total**
Under 20 years	3 (7%)	1 (6%)	2 (13%)	**6 (8%)**
20 - 25 years	14 (34%)	6 (33%)	2 (13%)	**22 (30%)**
26 - 30 years	15 (37%)	9 (50%)	2 (13%)	**26 (35%)**
31 - 35 years	7 (17%)	1 (6%)	4 (27%)	**12 (16%)**
36 - 40 years	1 (2.5%)	1 (6%)	4 (27%)	**6 (8%)**
Over 40 years	1 (2.5%)	0	1 (7%)	**2 (3%)**
Total	**41**	**18**	**15**	**74**

The average age of the women interviewed was 27 years, with the youngest woman being 15 years of age and the oldest being 50. Findings from this project indicate that age is an important variable in understanding substance misuse. The age of the woman was also an important variable in understanding the barriers that prevent pregnant women from accessing addiction treatment and their attempts to abstain from substance use. For example, women under the age of 25 were likelier not to see substance misuse as causing problems in their lives, and less likely to see themselves as having an addiction. These women perceived an "alcoholic" or "addict" as someone older than themselves, and usually someone who was male. These women were more concerned with their peer groups and were reluctant to give up using substances for fear of being judged by their friends. One young woman spoke about the pressure she received from friends to drink alcohol:

> ...Yeah, I cut down lots. I used to drink and do drugs almost every day. And then when the doctor told me [about the risk to the baby] and CFS told me, "Well, you got to stop or we're going to take your baby away when it's born." And then I said, "Okay," and I cut down a lot. I did it [cut down] where I was doing it every two weeks. But still that was lots. It would be a whole weekend of drinking and partying....
> **Question:** And did people encourage you not to use? For example your friends or anyone like that? Or were they judgmental?
> **Answer:** Yeah, they were judgmental. Well, they would tell me things like, "We don't want to hang around with you if you're not going to drink." You know, "You can't come here if you're not going to drink because this is a party house." I said, "Fine. I'll go somewhere else."

Recommendation 33: That Manitoba Health support programming aimed directly at women under the age of 25 that takes into consideration the contributing factors, such as peer pressure and perceptions of risk, typical to that group.

3. Problems of Substance Misuse

a. Participants' Substance Use

TABLE 4: PARTICIPANTS' SUBSTANCE USE	Winnipeg*	Thompson**	The Pas***	Total****
Self-reported addiction	38 (93%)	11 (61%)	13 (87%)	**62 (84%)**
Currently using substances	20 (50%)	11 (61%)	7 (47%)	**38 (52%)**
Poly-drug use when using	32 (80%)	13 (73%)	9 (60%)	**55 (68%)**

*Total number =41
**Total number =18
***Total number = 15
****Total number =74

To better understand substance misuse among pregnant women, this study began by asking participants to situate their use of substances within the context of their life histories. Women were asked to discuss their early use of substances and the role it played in their childhoods through to their current use or non-use of substances, including the periods when they were pregnant. Of the 74 women in the study, 62 (84%) reported having an addiction to one or more substances. The other 12 women reported that they did not feel they had an addiction problem but were included in the study because all of them reported misusing substances on one or more occasions during a pregnancy. While some of the 12 women may have a dependency on substances, it was not the goal of this project to make this determination. This group was interesting when compared to those women who self-identified as having problems with substance addiction. Those women who did not self-identify tended to be younger, and to be women who had not accessed addiction treatment despite their patterns of use being very similar to some of the other women who self-identified. This group reported more episodes of binge use rather than daily or regular use of substances, during pregnancy.

b. Substances Used

TABLE 5: SUBSTANCES USED BY PARTICIPANTS*	Winnipeg (N=41)	Thompson (N=18)	The Pas (N=15)	Total (N=74)
First substance used				
Alcohol	27	17	13	**57**
Marijuana	16	3	4	**23**
Inhalants	3	0	0	**3**

Main substance used					
	Alcohol	21	17	12	**50**
	Marijuana	2	3	0	**5**
	Cocaine	13	0	2	**15**
	Inhalants	3	0	0	**3**
	Hallucinogens	0	0	1	**1**
	Prescription drugs	1	0	0	**1**
	Talwin & Ritalin	2	0	0	**2**
	Methadone	1	0	0	**1**
Substance used regularly at one time	Alcohol	37	18	15	**70**
	Marijuana	28	10	9	**47**
	Cocaine	19	1	4	**24**
	Inhalants	10	1	1	**12**
	Hallucinogens	19	2	2	**23**
	Heroin	4	1	1	**6**
	Prescription drugs	3	3	0	**6**
	Talwin & Ritalin	6	1	1	**8**
	Methadone	1	0	0	**1**

*Some women reported using two substances simultaneously, such as alcohol and marijuana, as their main substances of use or their first substances of use.

Among the women interviewed, 38 (52%) reported that they currently used substances. Fifty-five women reported poly-drug use when they used substances, with alcohol being the main substance used by the majority of women (68%). Alcohol was also reported by 57 women as the first substance that they used, and among 82% of the women, alcohol was used regularly at some point in time during their lives. The average age of first substance use was 14 years, with the age of first use ranging from seven years to 25 years of age. The average number of years of use was 13 years. The use of illicit drugs was much more common among Winnipeg participants, particularly cocaine and hallucinogen use. Of those women in Thompson and The Pas who reported having regularly used illicit drugs at one time in their lives (with the exception of marijuana), this usually happened while they were living in Winnipeg or another urban centre. Participants in Thompson and The Pas reported increased availability of cocaine during the past five years.

Women were asked about substance misuse and addiction, particularly how they understood their own use within the context of their lives. For younger women, this was a more difficult question to answer than for older women. Many of the younger women did not see their use as a problem because they had less exposure to addiction treatment, whereas many of the older women had learned ways to understand and cope with their substance use. Older women in the study typically had more complex understandings of their substance use, and were likelier to link it to other aspects of their lives, such as past sexual or physical abuse, relationship problems, poverty, and low self-esteem. Even though some women had very complex understandings about their substance use, this did not necessarily mean that they were able to abstain from using. Many women discussed the ongoing battle they had with substance misuse in terms that were often very different than the views held by those who provided services to them. This was particularly true with regard to pregnancy and substance use, where most service providers had difficulty understanding why a pregnant woman could not, or would not, stop using substances while pregnant. This, coupled with the stigma of being pregnant and using, meant that women often isolated themselves from their most positive supports. One woman explained:

> I know I could have had support if I had wanted. But I felt very alone. I guess I kind of isolated myself. Because I knew that drinking during pregnancy was wrong. So I didn't want to see my parents. I didn't want to see anybody who would say anything to me.

Other women said that they found themselves justifying their behaviour in order to allow themselves to use. For example, one woman explained her substance use:

> That's the funny thing. When I was pregnant, I was kind of manipulating myself, I wouldn't touch a drink because I was worried about the effects it would have on my baby. I was going out and doing all this cocaine.

For other women, substance misuse and depression created a vicious cycle. One woman explained:

> …especially being pregnant…you know what, you get very depressed about being pregnant and doing drugs. "What am I doing to this baby?" And that pushes you more to do more. To feel

> less. The less you feel, the more numb you feel, the less you care, right?

c. Familial Substance Addiction

TABLE 6: SUBSTANCE ADDICTIONS IN PARTICIPANTS' FAMILIES	Number	Percentage
Winnipeg (N=41)	22	55%
Thompson (N=18)	11	61%
The Pas (N=15)	10	67%
Total (N=74)	**43**	**59%**

Many women reported substance misuse among close family members, particularly parents or caregivers, while they were growing up. Forty-four women (59%) reported that their parents or primary caregiver had a substance addiction, and in the majority of cases, this was identified as dependency on alcohol. Thirty-two women reported that they experienced either ongoing physical and/or emotional abuse by one or both of their parents, or neglect by one or both of their parents that was a direct result of their parent's substance abuse. A further result of this neglect and abuse was that these women were removed from the care of their parents by CFS on at least one or more occasions.

Women with parents who abused substances, linked the abuse to a number of negative childhood experiences (often involving violence) which the women felt directly contributed to their own misuse or dependency on substances. One woman explained:

> **Q:** And as a child what did you associate drinking with?
> **A:** Getting drunk. 'Cause that's all I ever saw. My mom wouldn't drink to casually drink. She'd drink to get drunk so when I started drinking it wasn't to have fun...So that's what my association with alcohol was. If you drink you get drunk. And that's all there is to it. You just don't have one. You drink until you're drunk. But it's only been in the past four or five years that I've realized that you don't have to drink to get drunk. You can have one.

Another woman spoke about the anger and despair she felt as a result of everything that had happened in her life:

> I just mostly partied. I was mad because my mom drank her life away. I don't know it was hard because at that time lots of stuff was going on in my life. I had sex abuse and my grandpa died and my dad died. Everything was going crazy on me so I just thought maybe drinking was the best way to get at her.

Recommendation 34: That Manitoba Health recognize the importance of inter-generational substance abuse—even when children are in foster care and not living with their biological parents—as a risk factor for substance misuse and addiction, and develop programs and services which address the substance misuse of parents and grandparents of pregnant women who misuse substances.

d. Foster Care

TABLE 7: PARTICIPANTS' FOSTER CARE EXPERIENCES*	Number	Percentage	Number in more than 5 foster placements	Percentage
Winnipeg (N=41)	17**	42.5%	14	35%
Thompson (N=18)	6	33%	6	33%
The Pas (N=15)	5	33%	4	27%
Total (N=74)	**28**	**38%**	**24**	**33%**

*Not all participants reported whether or not they had been in foster care as children.

**Two participants were eventually adopted. Two participants reported being sexually, physically and emotionally abused while in foster care.

For some women, one of the most negative outcomes of their parents' misuse of substances was that they ended up in foster care as children. While many of the women recognized that their parents were unable to care for them at the time and that an intervention by CFS was necessary, their experience as foster children was often recounted as an extremely negative experience mainly due to multiple placements. Of the 28 women who reported being in foster care or in group homes as children, 24 had been placed in more that five different foster homes. In one instance, a participant reported being in more than 20 different homes before turning 18. In some cases, women reported being placed in a hotel room under the supervision of caregivers who worked in shifts caring for them because there were no foster homes available.

The common occurrence of multiple placements in more than five foster homes was also supported by interviews with service providers who were seeing many clients who had been moved around in foster care during their childhoods.

> **Q:** How was it moving from foster home to foster home? How did you feel?
> **A:** Mostly like I was a piece of junk, that's what I felt all my life. I'd get used to one home and then I'd get attached to it and then I'd have to move and do it over and over and over and over and over again.

For many of the women who had been in foster care or group homes as children, the experience was painful and difficult to talk about. Women reported being abused while in foster care, having disrupted childhoods and difficulties adjusting to new foster parents, schools, and friends. Many reported running away and living on the street until they were picked up by police and returned to the foster or group home. During their time on the street, participants were introduced to a number of illicit activities, such as illegal drug use, prostitution, and theft. Many of the women experienced violence and abuse directed toward them by other youth, or older street people, particularly men. For many women, their time on the street was a transitional period when they increased their substance use and their involvement in illegal activities significantly. It was usually at this point that many also reported becoming pregnant for the first time. One woman discussed her experience as a youth:

> **Q:** And so as a child living on the street, what kind of support did you have from different organizations?
> **A:** Absolutely nothing. Other than the police trying to push us off the streets, which it didn't help because it just pushed us further into the dark corners that was it. Police would pick us up. Maybe catch you once a week. Bring you to the Marymound and you'd sign yourself out and away you went in your taxi back to work [on the street] again.

Another woman spoke about how easy it was to get drugs when she was a teenager:

> It's easier to obtain cocaine at 16 than it is to buy cigarettes or get alcohol. It is. People walk, even down in the Core Area, they walk on the street selling rock cocaine to 12-, 13-year-old kids.

For other women, foster care and group homes were a positive development in their childhoods, removing them to safer, stable environments. However, in many of these cases, the women spent a great deal of their childhoods moving in and out of foster care, depending on the circumstances of their biological parents. In these cases, there was often sadness over the loss of relationships with foster parents who had a positive impact on their childhood years.

Aboriginal women in this study were more likely to have been in multiple foster placements. Typically, these women were placed with non-Aboriginal families where they were not exposed to aspects of their culture or identity. This was extremely difficult for many women who ended up seeing their Aboriginal-ness as something negative and of which to be ashamed.

Added to the problems of multiple foster placements was the difficulty women had once their foster placements ended because they were no longer wards of the state. During this period, women reported that they felt isolated and alone because they were expected to move out of their foster homes and into lives as independent adults. While some women maintained ties with their foster families, others reported having no one to support them during this transition. Many of them had very limited financial resources. The combination of these factors significantly contributed to some women becoming street-involved at a very early age.

Recommendation 35: That Manitoba Health, in conjunction with CFS agencies, find ways to decrease the number of foster placements a child may experience, and provide support services for transitional periods, such as movement between foster placements or movement of older adolescents out of foster care, to assist in healthy adjustments.

Recommendation 36: That Manitoba Health, in conjunction with CFS agencies, support the placement of Aboriginal children with Aboriginal foster families when at all possible, and when this is not possible, that foster families of Aboriginal children have knowledge of Aboriginal support services, and promote a strong, positive sense of Aboriginal identity for the children they foster.

4. Other Factors

a. Mental Health Problems

TABLE 8: PARTICIPANTS' REPORTED MENTAL HEALTH PROBLEMS*	**Winnipeg (N=41)**	**Thompson (N=18)**	**The Pas (N=15)**	**Total (N=74)**
Chronic or long-term feelings of depression, stress, isolation, and/or suicidal thoughts	39 (97.5%)	17 (94.4%)	12 (80%)	**68** **(92%)**
Suicide attempts	6 (15%)	0	2 (13%)	**8** **(11%)**

*Other reported mental health problems were fear of leaving the house, obsession with cleanliness, extreme fear of physicians and dentists, anger, need for control, not being able to cope with children, and violence toward other adults

Women were encouraged to discuss what they saw as the most important contributing factors to their misuse of substances. The most often discussed issues concerned feelings of hopelessness and helplessness. A large majority of the women discussed ongoing feelings of low self-esteem, frustration and despair. Sixty-eight (92%) of the women interviewed expressed *chronic* feelings of depression, stress, suicidal thoughts, and isolation from positive support networks.

For these women, attempts to change or improve their life circumstances were recounted through narratives in which they spoke about insurmountable psychological, emotional, and environmental obstacles. In these narratives, the central place of substance misuse was evident as a coping mechanism, self-mediation, and a form of empowerment. One woman stated:

> After I'd come down, I'd get depressed. And then as soon as I started feeling that way I'd want more to take away the depression. Like one was never enough. I'd always need more. 'Cause, like, after you came down you'd start feeling down and all the pain that you are trying to run away from comes back. And you want more.

Another woman explained how her reasons for drinking changed as she became older:

> Well, for me as I grew up and I was drinking it was just for fun. And now when I drank for the past three years I've noticed because I was really depressed and I have a lot of problems. And I didn't even want to be sober. It's like I didn't care. Where as before it was just for fun. Like, I noticed I was drinking by myself. Because I was depressed…I was going through a breakup at the time. So that had a lot to do with it. And yeah, there's the thing too of always being out of money for food and stuff like that. I was always worried where am I going to get food for my kids if I ran out of stuff. And money.

A third woman spoke about her addiction in relation to childhood abuse and how it affected her ability to acknowledge her pregnancy and the subsequent birth of her baby:

> I know one thing about myself, that is of my addiction, basically where it stems from. I have an abuse background. At the time, especially after I had my baby, my child. I guess my personal issues, all the negative feelings were coming up and stuff. They overrode some of the comments to be healthy, treat yourself healthy. Well, for me, someone could say the pain and all that was too

> much. My baby, I didn't even acknowledge it as a baby. And then when she was born, she had to be on medication and I can't remember why.

At other times, substance misuse was discussed as a force that was too powerful to fight. For example, one woman explained how her addiction and the activities she had to engage in to buy drugs meant that she felt disconnected from her body. This had an impact on her feelings about her pregnancy and the baby she was carrying:

> …with an addiction it's really hard to put anything else above that addiction, especially ourselves. Even though we're carrying a baby, yes, but we have such low self-esteem in most cases or such low respect for ourselves that it really doesn't matter. Sure this is my body but it's only here in vision. It's really gone somewhere…It's here to get your attention so you'll pick me up but you know but other than that I don't really care what you're going to do to it. I'm just thinking you're giving me money, I'm going to go get high. That's basically what it is and it's a sad thing to think, but yeah, most addicts do think that way.

Recommendation 37: That Manitoba Health recognize the link between mental health problems and substance misuse, and in conjunction with mental health agencies and addiction services, find ways in which gaps in service provision for women who struggle simultaneously with mental illness and substance misuse can be addressed. Within this framework special attention should be paid to the interplay of pregnancy, mental illness and substance misuse.

b. Sexual Assault and Abuse

TABLE 9: PARTICIPANTS WHO REPORTED BEING RAPED OR SEXUALLY ABUSED	Number	Percentage
Winnipeg (N=41)	16	40%
Thompson (N=18)	2	11%
The Pas (N=15)	6	40%
Total (N=74)	**24**	**33%**

Among the women interviewed, one-third reported being raped or sexually abused at some point in their lives. These were very painful and traumatizing events for women to talk about, and were directly linked by the women to their substance misuse. For many of these women, their attackers had not been prosecuted, and in some cases, were individuals they still had to deal within their families, communities, or circles of friends. Many of the women felt silenced by the perpetrators, and the majority of women had received no informal or formal counselling for the abuse. In other cases, women reported that in some addiction treatment groups, they were pushed to discuss past abuse when they felt they were not ready to disclose what had happened.

One woman who was interviewed talked about how her life changed after several consecutive events, including being raped and having her boyfriend reject her when she was pregnant with his child:

> …I became a hooker when I was 22 'cause I thought, "What the hell, my boyfriend don't love me no more. Nobody gives a shit. The hell with everybody. I'll just go to work and make some money."
>
> **Q:** Were you using substances then?
>
> **A:** The only thing I ever did was, like, I'd drink and I'd smoke dope and that. Those are the only substances that I used. But I found myself when I did go to work, to go make money I found I had to have a little kick, like, a little toke or else a couple of beers. You know, just to get myself up. You know, high?

c. Physical Violence

TABLE 10: PARTICIPANTS' WHO REPORTED BEING VICTIMS OF PHYSICAL VIOLENCE BY A PARTNER	Number	Percentage
Winnipeg (N=41)	19	47.5%
Thompson (N=18)	5	28%
The Pas (N=15)	9	60%
Total (N=74)	**33**	**45%**

Along with reports of sexual violence, many women reported being the victims of ongoing physical violence by a partner. For many women, being physically abused by their partner(s) was part of their everyday lives. This was often combined with emotional and psychological abuse, and at times was directed not only toward the woman, but also toward her children. Many women, despite recognizing the danger they were in, either stayed with, or continued to return to, their abusive partners. It should be understood that the instances of physical violence experienced by these women were not isolated experiences, nor were they instances where minimal violence was experienced—these were cases where women experienced ongoing violent acts committed against them to the point where they often had to be hospitalized or were in need of a physician. Many of the women felt trapped in these relationships, fearing that if they left their partners they would be tracked down and hurt even more, or that they would be completely alone (which to some women was worse than putting up with the abuse). One woman spoke about her feelings concerning abusive relationships and how she had come to expect and live with the abuse:

> You know, I've been abused when I was a little girl by my dad. Then I thought, "That's the way I'm supposed to be loved is if I'm getting abused by my boyfriends." My boyfriends used to abuse me. So I'd think, "Why should I be scared all my life? I have to face it sometime," and thought being with the same kind of people, eh? I can't run away, I can't be scared all my life.

Another woman spoke about how her use increased because of an abusive relationship:

> **Q:** Did your use of substances decrease when you had your children?
> **A:** Well, I did when my boys were small and [living] with me. Well, I did it with them. But then after that I didn't do it for about two years, three years. And then I was living with an abusive man. He used to beat me up all the time. And I started doing everything again. Then I phoned my sister up and she came and got me. I came to Winnipeg and I started using again and I lost them [her children to CFS].

Fifty-seven women (77%) reported an increase in relationship problems with their partners when they and/or their partners increased their substance use. Conversely, 56 women (76%) reported that increased relationship problems contributed to their increased use of substances.

d. Extreme Physical, Emotional, and Sexual Abuse and Neglect

TABLE 11: PARTICIPANTS WHO REPORTED BEING THE VICTIM OF EXTREME PHYSICAL, EMOTIONAL, AND/OR SEXUAL ABUSE, AND/OR NEGLECT	Number	Percentage
Winnipeg (N=41)	30	75%
Thompson (N=18)	11	61%
The Pas (N=15)	11	74%
Total (N=74)	**52**	**71%**

Past sexual, physical and sexual abuse, as well as childhood neglect, were reported by the majority of women as contributing factors to their substance misuse. Among the women who did not experience abuse or neglect, many reported fewer problems related to substance misuse, a more secure and stable childhood, a greater number of people in their support networks, better relationships with partners, friends and family, and better relationships with service providers. However, better socio-economic circumstances did not correlate with fewer experiences of abuse or neglect.

Recommendation 38: That Manitoba Health provide avenues for women with substance misuse problems to access individual counseling for issues such as past sexual, physical, and emotional abuse, suicidal thoughts, chronic depression, and other mental illnesses.

5. The Experience of Pregnancy

> There are women who I've met, one woman in particular had eight children and her eighth she asked me to be at the hospital…She knew that she couldn't keep the baby. But I saw her all the way through. She would talk about using less. Trying to use less to provide for her baby. At the

> same time her emotional pain was so huge and so dominant that she couldn't quit all together. It would be just too overwhelming. She felt like she had to die. So I see people struggling with their addictions around their pregnancies and I don't think that anybody wants to hurt their baby. I don't think it's because they don't care.
>
> *- Winnipeg Service Provider*

TABLE 12: PARTICIPANTS' PREGNANCIES	**Winnipeg**	**Thompson**	**The Pas**	**Total**
Number of pregnancies	172	66	41	**279**
Average number of pregnancies	4.2	3.6	2.7	**3.8**
Number of births	110	48	38	**197**
Number of miscarriages	29	8	2	**39**
Number of abortions	21	0	0	**21**
Currently pregnant	12	10	1	**23**
Number of children*	108	47	38	**193**
Average number of children	2.6	2.6	2.5	**2.6**
*Four of the 197 children born had died				

In collecting data for this project, pregnancy and addiction were two areas of interest, including how women deal with them simultaneously in their lives. Among the 74 women interviewed, they had 279 pregnancies collectively, or an average of 3.8 pregnancies per woman. Of these pregnancies, 197 ended in live births. Twenty-three women (31%) were currently pregnant when interviewed.

a. Abortion

While 12% of the pregnancies among the women from Winnipeg ended in abortion, there were no reported abortions among the women from Thompson or The Pas. The main reasons given by women for choosing not to terminate a pregnancy were cultural or religious beliefs, inaccessibility, pressure from family and partners not to abort, and fear of being stigmatized. Several women in Winnipeg who had considered abortions also cited these reasons. In some cases, the reason a pregnancy was unwanted was because it was the result of a sexual assault or a sexual encounter with a "john."

The reasons why women had abortions varied. In some cases, the pregnancy was terminated simply because the woman did not have enough support in her life and was too overwhelmed by her circumstances to continue the pregnancy. One woman explained how she made her decision:

> I had an abortion because I was hooked on drugs and I had a child and I was thinking, "Frig, I can't afford to have another child." I couldn't do it. Welfare would not give me enough money. It was hard enough for me to keep up my addictions, to keep up my home and groceries for my little girl already. I was scared and I just didn't know what to do. I told them, I said, "What am I supposed, you know, to do?" My doctor suggested, "Well, there's other choices, you can have an abortion, you can adopt." Adoption is the furthest thing from my mind. I don't believe in it. I can't handle it. If I can't keep that baby there's no way I'm giving it to somebody else…What if you give it to some monster that you don't know about? That's my fear. Because working the streets I see these monsters, I know. I see them come by with Wal-Mart catalogues and stuff. It freaks me out…My friends just told me, "You made a choice and now the choice is done and over and then you just sweep it under the carpet, put it in the back of your head and deal with it in a couple years. If you try and deal with it now it'll just break your heart." And it broke my heart because I had a little girl and I was looking at her knowing that I just killed another one. And then, shit, how could I do that? And then I felt really bad when I got pregnant with her [her next child] and I found out so late and I had to have her. You know, and God forbid that I say this, but if I had found out earlier I don't think she would have been here. She was like a gift. She broke the life cycle [of substance abuse] for me.

Four women reported unsuccessful attempts at using large amounts of substances to terminate an unwanted pregnancy. When asked why they did not have an abortion, all four women responded that they did not believe abortion was the morally correct thing to do. In some cases, women felt they had no one with whom to discuss their options concerning abortion because the service providers they accessed were against it.

Recommendation 39: That Manitoba Health, in conjunction with women-centred health programs, such as the Women's Health Clinic, ensure that women have access to abortion counseling and services in all parts of the province, and that women have meaningful options if they do not want to have an abortion but feel they are ill-equipped to have a baby at that particular time.

b. Birth Control

Many of the women's pregnancies were unplanned because they were doing nothing to prevent pregnancy from occurring. For the majority, birth control was simply not a priority, and in some cases, women seemed to be indifferent about becoming pregnant ("If it happens, it happens"). For the most part, women had access to some form of birth control. Women interviewed in Thompson and The Pas were more likely to be using some form of protection than women in Winnipeg (for example, DepoProvera® and birth control pills were used by more women in Thompson and The Pas than women in Winnipeg). However, the sample population is too small to draw any conclusion from this.

Some women reported that they were not using a form of birth control because they wanted to get pregnant. Their reasons for wanting a child varied but corresponded with common reasons why women in general want to have children, such as feeling ready to start a family. Other reasons were more specific to the group interviewed. For some, having another child was an opportunity to change their lives (this was particularly true for women who had other children in the permanent care of CFS and women who were currently struggling with their addictions). Other women wanted to have a baby because they identified strongly with being a mother and drew much of their self-worth from this role. Some women wanted to have children so that they would have someone to love and/or someone who would love them. Other women wanted children to better secure their relationship with a male partner. Some women wanted to get pregnant because they had recently stopped using substances. For many women completing an addiction program, being substance-free was a time of optimism and positive change. While many women were interested in regaining custody of children, some were also interested in having more children. In many cases, women wanted to get pregnant because their partner wanted a baby.

Some women had tubal ligations so that they would not have any more children. These women reported that having a tubal ligation was a choice they made willingly, or that they were coerced into having the procedure. For example, one woman spoke about her decision to have a tubal ligation after the birth of her son:

> After my son was born I felt total guilt over the drinking while I was carrying him that I had my tubes tied. Well, the guilt was just eating me up inside and it does today. You know I think could my son have been smarter if I didn't drink? Could he have been more athletic? Could he have been more anything? You know, just a better person...?

Examining the use of birth control by women who misuse substances was not a central goal of this project. However, the fact that a large majority of women in this study rarely used birth control raises concern, particularly because their reasoning does not seem to be based on lack of information or access. The women were, for the most part, well-informed and had access to some form of birth control. However, many women outlined reasons why birth control options did not work for them, and felt they did not have a viable option to prevent pregnancy. The most common reasons given for not using birth control were problems negotiating condom use with partners; a partner thinking she was cheating on him if she wanted to use birth control; a partner who did not want her to use any form of birth control; the woman did not like using condoms; difficulty remembering to take a pill every day because her lifestyle was too chaotic; side effects from birth control pills and DepoProvera® (nausea, weight gain or loss, prolonged menstruation, mood swings and depression); fear of using an IUD; and not believing that she could get pregnant.

c. Substance Use During Pregnancy

TABLE 13: PARTICIPANTS' SUBSTANCE USE DURING PREGNANCY	**Winnipeg (N=41)**	**Thompson (N=18)**	**The Pas (N=15)**	**Total (N=74)**
Stopped using during one or more pregnancies when she found out that she was pregnant	22 (54%)	7 (39%)	5 (33%)	**34 (46%)**
Did not stop using during one or more of her pregnancies once she found out that she was pregnant	33 (80%)	17 (94%)	10 (67%)	**59 (80%)**
Cut down substance use during one or more of her pregnancies once she found out that she was pregnant	23 (56%)	16 (89%)	6 (40%)	**45 (61%)**
Did not cut down substance use during one or more of her pregnancies once she found out that she was pregnant	19 (46%)	3 (17%)	4 (27%)	**26 (35%)**
Started using again during one or more of her pregnancies after she had cut down or quit using	13 (32%)	12 (67%)	3 (20%)	**28 (38%)**
Used substances during her pregnancy because her partner was using	22 (54%)	10 (56%)	5 (33%)	**37 (50%)**

Women were asked to talk about their use of substances during their pregnancies. For the large majority of women, use of substances first occurred before they knew that they were pregnant. In some cases, women reported being four to five months pregnant before knowing that they were expecting a baby. In these cases, women usually were experiencing ongoing spotting, which led them to believe they were menstruating, not pregnant. For some women, realizing that they were pregnant at these later dates meant that they did not have a choice to terminate the pregnancy.

Among the women interviewed, 34 (46%) reported that they stopped using substances during one or all of their pregnancies once they found out they were pregnant. Fifty-nine (80%) women reported that they did not stop using during one or more of their pregnancies once they found out they were pregnant. While it was more likely that women would not stop using during their pregnancies, the data suggest that women are more likely to cut down their use when pregnant (for example, 45 women (61%) reported they reduced their use during one or more of their pregnancies once they found out that they were pregnant). Twenty-six (36%) reported not cutting down on their substance misuse for one or more of their pregnancies once they found out that they were pregnant. Of the 74 women interviewed, only nine women (12%) reported they had no information during one or more of their pregnancies that substance misuse may cause harm to their fetuses. However, women had more information with subsequent pregnancies.

For the most part, women were informed at some level about the health risks to the fetus. However, the women reported receiving mixed public health messages from different service providers and from information obtained from other women. For example, service providers held differing views as to whether damage to the fetus could be caused in the first three to four weeks of pregnancy—a time when most women in this study did not know they were pregnant. Some service providers believed that this was a crucial time in fetal development when the fetus was particularly vulnerable, especially if the woman was consuming excessive amounts of alcohol. Other service providers believed that damage to the fetus was not likely to occur during these first weeks, and that the fetus was much more vulnerable after the first month of pregnancy. Differing views about risk were evident in interviews with service providers, supported by women's accounts of the advice and information they received.

Recommendation 40: That Manitoba Health recognize the central role that alcohol plays among women who misuse substances, and continue to focus on this central role in prevention and intervention programming.

The type of substance misuse during pregnancy varied among the women, and also among their different pregnancies. It was not uncommon to have the same woman use substances on a daily basis for one pregnancy and then cut down her use considerably for another pregnancy. However, it should be noted that a decrease in substance use did not necessarily occur with subsequent pregnancies. In many cases, women used fewer substances during their earlier pregnancies than in later ones. Nineteen (26%) stated they used one or more substances on a daily basis throughout at least one of their pregnancies. Thirty-four women reported regular use (roughly two to four times a week) of substances during at least one of their pregnancies. Interestingly, in recounting their substance use during pregnancy, it became clear that it was understood in relation to binge use in which the person used enough substances to be "drunk," "high," or to "pass out." Having a minimal amount of alcohol (not enough to get "drunk") or other substances was often not considered "substance use," which may contribute to women under-reporting their substance use when asked by service providers such as obstetricians.

Thirty-two women (43%) reported regular binge use (more than once a week) during one or more of their pregnancies, and 35 women (47%) reported infrequent binge use (roughly once a week to once a month) during one or more of their pregnancies. Infrequent binge use was extremely interesting in relation to the ways in which the women understood the public health messages given to them. While approximately 61% of the women reported cutting down their use of substances during one or more of their pregnancies—which they understood as being a way to improve the outcomes of their pregnancies—many women did not make the distinction between the potential risk of minimal substance use as opposed to consuming large amounts of substances at one time.

Recommendation 41: That Manitoba Health create a public health campaign that specifically identifies binge use of substances during pregnancy as a health risk to a woman and her fetus.

In making the decision to use, some women reported that the opinions of those around them made a difference, particularly those of their partners. This was particularly true for women who did not use substances on a daily basis but tended to be binge users. One woman explained her alcohol use during pregnancy:

> ...I found out I was pregnant. For the first, I think month and a half, I didn't drink. And then we went to a bar and my ex-husband was like, "Well, you know the doctor said that one beer won't hurt the child," and this and that.
> **Q:** And did the doctor say that?
> **A:** Yes, he said actually one beer would not hurt the child. It would be just fine. As long as it's just one beer. But for a person who has an addiction to it, it's not going to be just one beer. And I should have thought of that but I didn't. I just sipped it very slowly and it tasted good. "Oh, one more is not going to hurt," and then it just escalated from there.
> **Q:** And what did your husband say at the time when he saw you drinking more?
> **A:** At first he was like, "No, you shouldn't do that," and then he says "Okay, just this one time." And so at first it was "No, no, don't." And after a while it was like, "Okay, just this one time you can do this. It's okay this one time." I did it, then I did it again, and then I did it again.
> **Q:** So how often would you say that it was happening?
> **A:** About once a month.

In relation to the public health message, none of the women recalled seeing a public health poster which gave information on binge use. For the most part, women felt the public health message was mainly about alcohol use, and that it promoted only an abstinence message. Therefore, whether one used a lot or a little did not seem to matter that much. What mattered most was that a pregnant women should not use. Abstinence, according to many of the women, was also the message given by most service providers. However, following this public health message was simply not a viable option for many of the women.

> **Q:** Were you anxious during your pregnancy because you had been using and the public health message said this could cause problems for your baby?
> **A:** Yeah, I was worried. But I just never had enough support to quit. I felt just too alone.

Among those women who reported that they cut down or stopped using substances once they found out that they were pregnant, a percentage later increased their use of substances. This particular change in behaviour was often linked to a breakdown in a woman's support network, a crisis situation occurring, or an inability to cope with daily circumstances without the use of substances. For example, of the 28 women who increased their use of substances after they had cut down or quit using, 57% stated that a reason they increased their use was due to the difficulty of dealing with feelings of depression, isolation, loneliness, stress and painful memories. One woman stated:

> So I play a lot of solitaire. I do a lot of crossword puzzles at night. Night is the worst time. I don't crave at night but I'm just so lonely.

TABLE 14: PARTICIPANTS' REASONS FOR INCREASING SUBSTANCE USE DURING PREGNANCY AFTER A PERIOD OF ABSTINENCE OR DECREASED USE	**Number (N=28)**	**Percentage**
To cope with painful memories, depression, stress, and loneliness	16	57%
Other children apprehended	3	11%
Partner died	2	7%
Partner went to jail	2	7%
All her friends were using	6	21%
Finished and/ or left addiction treatment	4	14%
Told that fetus would go through withdrawal and be born sick if she cut down too much	1	4%
Marijuana helped with nausea, increase in appetite sleeplessness and stress	2	7%
Cut down on everything, increased marijuana use because it was less harmful	2	7%
Problems with relationship with partner	17	61%
Uncontrollable urge to use again	1	4%
To cope with fear of miscarriage	1	4%
Pregnancy result of rape, could not cope	1	4%
Told by hospital worker that baby would be sick because of her early use in the pregnancy, could not cope with knowing she had hurt her unborn baby	1	4%

An important finding is that most service providers who were interviewed focused on what they saw as a relationship between the pregnant woman and her fetus or "unborn child." One of their main goals was to impress upon women that their substance misuse could cause harm to their fetuses. It was difficult for many service providers to understand why a pregnant woman who knew the risks would continue to put her "unborn child" at risk. However, women in this study highlighted the importance of other relationships, particularly those with partners, family members and service providers as being significant to this equation. For example, 61% of women reported increasing their substance use during pregnancy after they had cut down or quit, and that relationship problems with their partners were a major factor in their increased use. In many instances, these problems involved partners leaving the relationship (sometimes for other women), physical abuse, lack of support, or partners not wanting another baby or claiming that they were not the father of the baby the woman was carrying. For example one woman spoke about her experience:

> So I ended up getting pregnant again…and the guy messes around on me. And I'm just like,

> "God, I can't do this, what am I suppose to do abort this baby because he cheated on me you know?"...And when I was depressed I was aware of myself being depressed but I couldn't be depressed because if I was depressed then how would I cope? I would just be screwed. And that's it. And so I would try my best to make it better. It seemed like when I did cocaine it just made everything much more easier. You know, like I was high and whatever. You know, hanging around the people I was with, it's just like they don't give a shit. It's like, "Ah, let's get high and shit."

Over and over, women reported misusing substances during their pregnancies because of relationship problems with male partners, family members or service providers. For many, abusing substances was a way to forget and cope with relationships in which they felt powerless. At other times, abusing substances was a form of protest—a way for pregnant women to lash out at those who were hurting them. Abusing substances was a way to impress upon male partners, family members and service providers the degree of pain they had caused. In some cases, the only way women felt they could show the depth of their pain was to use extreme amounts of substances, preferably in view of the individual(s) to whom they were responding. Because this was often the way in which they dealt with relationship problems when not pregnant, many women turned to substance abuse when pregnant. Furthermore, some women felt they were more likely to get a hoped-for response—such as stopping a partner from cheating on them—if they threatened to continue to abuse substances during the pregnancy.

Relationships women have with male partners, family members and service providers are complex. Reducing substance misuse during pregnancy to an issue concerning a pregnant woman and her "unborn child" is to risk overlooking relationships that are as important or more important as contributing factors to the problem. For many women, their fetuses remained abstractions through most or all of their pregnancies, particularly if the woman was using heavily. Even though women knew their substance misuse placed the health of their fetus at risk, and they experienced feeling of guilt and anxiety about this, responding to more immediate "real" circumstances, such as relationship problems with male partners, often overrode other concerns.

Relationships with CFS workers, particularly around the apprehension of children, resulted in some women increasing their substance use, including those who were pregnant. While apprehension is at times a necessary measure, it often prompts women to increase their substance use and reject support services. This is a difficult situation for CFS workers, particularly if the woman is pregnant, because it may result in the fetus being placed at increased risk. One pregnant woman explained how she felt after CFS took her children:

> Nothing mattered to me. Like, I was just to that point where I didn't care anymore. I guess I was, maybe I was, probably I was trying to kill myself. [That's] why I went so many days without food. Like, I was shooting up ten days in a row and when I finally went back to my cousin's place, like, they said my face was just sunken in so deep that they could see the bones on my face. Like, I didn't care about anything after they took my kids away.

For the women, pregnancy must be understood within the context of their life circumstances. This includes realizing that for some women with substance misuse problems, pregnancy can be a strong motivating force to help them address their problems, while for others pregnancy only adds to the overwhelming myriad of issues that they cope with through substance misuse. Two women explain:

> I found that none of the programs ever worked for me. You're looked upon so negatively 'cause you're addicted for one, and you've been addicted for a long time and now you're pregnant and addicted. That's the hard part. And the guilt over what you're doing. But you have no control. It's a loss of control. The crack [cocaine] keeps you, you don't keep it.

> If I wouldn't have got pregnant I don't think I would have quit. My baby was my saviour. The pregnancy alone didn't force me to quit. It was after…

6. The Women's Children

TABLE 15: PARTICIPANTS' CHILDREN	Winnipeg	Thompson	The Pas	Total
Total number of children	108 (56%)	47 (24%)	38 (20%)	**193 (100%)**
Number of children in the care of their biological mother	43 (40%)	10 (21%)	21 (55%)	**74 (38%)**
Number of women who have custody of one or more of their children	25 (61%)	12 (67%)	10 (67%)	**47 (64%)**
Number of children in the care of CFS	18 (17%)	10 (21%)	10 (27%)	**38 (20%)**
Number of women who have children in the care of CFS	10 (24%)	6 (33%)	4 (27%)	**20 (27%)**
Number of children in the care of the biological father	10 (9%)	7 (15%)	4 (11%)	**21 (11%)**
Number of women who have children that are in the care of the biological father	8 (20%)	3 (17%)	2 (13%)	**13 (18%)**
Number of women who have children that are in the care of a family member as a foster or adopted child	13 (31%)	3 (17%)	2 (13%)	**18 (25%)**
Number of children in the care of a family member as a foster or adopted child*	25 (23%)	4 (9%)	3 (6%)	**32 (17%)**
Number of children adopted by non-family member	8 (20%)	1 (2%)	0	**9 (5%)**
Number of women who have children that are adopted by a non-family member	6 (15%)	1 (6%)	0	**7 (9%)**
Number of children not living with their biological mothers	61 (57%)	22 (49%)	17 (45%)	**100 (52%)**
Number of women who do not have custody of any of their children	13 (31%)	5 (28%)	5 (33%)	**23 (31%)**

*These children are officially in the care of CFS, and when combined with the number of children in the care of CFS and the number of children who have been adopted by a non-family member, account for 41% of the children of the women interviewed.

Data from this study suggest that pregnancy is an important window of opportunity to encourage women to seek help for substance misuse. However, for various reasons the majority of women did not want to attend treatment while pregnant. The main reasons included fear that their babies would be apprehended at birth, their partner did not want them to go to treatment, or fear of the stigma of being pregnant and needing addiction treatment. Data also suggest that coordinated efforts by service providers in a respectful and non-judgmental manner can result in pregnant women seeking support services which will help them decrease or stop their substance use.

a. Children's Health Problems Related to Mother's Substance Use

Women interviewed collectively had 193 children at the time of the study. Sixteen women (24%) reported that they had one or more children who were physically affected by their substance use while pregnant (27 children in total). These accounts included both effects that were diagnosed (such as FAS) or other undiagnosed effects that the women *felt* were the direct cause of their use, such as chronic ear problems and heart murmurs. According to the information given by the women, five children had been formally diagnosed with FAS and three with FAE. This represented 4% of the children. None of the women reported that their children had been diagnosed with other related illnesses such as alcohol-related birth defects (ARBD). It should be noted that the rate of formal diagnosis may be higher, as some women were not sure if their children had been formally diagnosed because the children were living outside of their care. Women saw other problems as being caused by their substance use while pregnant, including prematurity, withdrawal symptoms, low birth weight, hyperactivity, anger, problems in school, slow weight gain, heart murmur, asthma, developmental delays, and problems with loud noises. None of these symptoms were reported in more than five per cent of the children.

Fifty-eight women (78%) reported that one or more of their children experienced no health problems as a result of their substance use while pregnant. However, 19 of these women reported that they were fearful that a health problem might emerge later in their children's lives (the age range of the women's children was from infancy to adulthood). For many women, a contradiction existed between the public health message and their experiences. This was further reinforced by the experiences of other women around them, such as their mothers, sisters, and friends. Giving birth to a baby who was not affected by the mother's substance misuse contributed to the woman's perception of decreased risk in subsequent pregnancies.

b. Apprehension of Children

TABLE 16: APPREHENSION OF PARTICIPANTS' CHILD(REN)	**Winnipeg (N=41)**	**Thompson (N=18)**	**The Pas (N=15)**	**Total (N=74)**
Women who currently or in the past have temporarily or permanently lost legal custody of their children	36 (88%)	8 (44%)	8 (53%)	**52 (70%)**
Number of women who had children apprehended because of substance misuse	27 (66%)	8 (44%)	8 (53%)	**43 (58%)**
Number of women who reported increased substance misuse after their children were apprehended	25 (61%)	8 (44%)	8 (53%)	**41 (55%)**

Of the 74 women in this study, only women in the Winnipeg group reported having a "birth alert" placed on them during one or more of their pregnancies. A "birth alert" happens when a Child and Family Services agency has a strong reason to believe that a woman who is pregnant will not be able to properly parent her newborn. When the woman has the baby, CFS intervenes at the hospital to take the child into care. Sometimes the child remains with the mother under the supervision of CFS. At other times, the baby is placed in a foster home. Some of the pregnant women interviewed for this study had "birth alerts" currently in place. All of these women were attending either residential or outpatient addiction treatment programs. However, there were women in the study who had "birth alerts" placed on them but had not gone to addiction treatment during their pregnancies, either because they were never referred to a program or because they decided not to go. One pregnant woman who currently had a "birth alert" placed on her talked about her fears of having her baby because of what had happened with her last pregnancy:

> ...Well, the baby I had last year was born with cocaine withdrawal and alcohol withdrawal. And like, I didn't want this baby to be born that way. 'Cause she was in the hospital for almost two weeks. They had her on an IV and they were giving her medication for, 'cause she had the shakes and all that. Tremors and she was really stiff. Like, I thought to myself, "How could I do this to my baby?" But while I was pregnant, I was just thinking about the pain and loneliness that I was going through. And I didn't think of my unborn child...I didn't want this baby to go through the same pain that she went through, see? But they took her for tests to see if she had FAS or FAE and she doesn't. She got lucky there. But they don't know yet whether she is going to have learning disabilities. She is too young. So I don't know how she'll be. We'll be able to tell when she gets older. Right now she seems okay. She's walking and talking and everything. So I just didn't want to put this baby through the same thing that that baby went through...Like, with this one I didn't want to get my hopes up. Like, I didn't want to start to love this baby because of Child and Family, but I did. It was hard not to after I started feeling the baby.
> **Q:** The kicking and stuff like that?
> **A:** 'Cause I told my boyfriend that I don't know if I can handle all the pain again. I might lose

> another baby.

Another woman explained the advice given to her by CFS when she was pregnant:

> A CFS worker came to see me and she told me, she said, "It's the best that you get something to help you to not have babies because from now on you're always going to have this birth alert." She says, "Every time you're going to have a baby, they're always going to apprehend the baby."

One woman explained how she responded to CFS after they apprehended her first baby:

> After I had my firstborn I had told my CFS worker, "I'm going to keep having kids until you let me keep one." That's what I told them, and I kept that theory.

The impact of babies being apprehended at birth was traumatic for the women. Women who had their newborn babies apprehended reported that there was very little support to help them deal with the emotional and psychological pain it caused. Typically, women were told by CFS that they must comply with a number of requirements, such as attending addiction treatment and going to parenting classes. However, the insensitivity shown by some workers was evident. For example, one woman spoke about her experience attending parenting classes after the birth of one of her children:

> ...I didn't know how to parent. I had not really gotten a chance to parent. I remember one time they [CFS] did make me go, CFS tried to make me go to parenting classes. I went to one class. The reason I didn't go back was everybody still had their kids with them.
> **Q:** And you didn't have your kids?
> **A:** No, mine were taken away. Everybody had their kids with them and I'm like…I felt very uncomfortable there and I never went back. And they asked me how come I didn't finish this. I tried to explain to them. They said, "Well, that's not good enough, you should have kept up with it. You would have been closer to [getting your children back]." And even with CFS, I don't like CFS at all. I can't stand them because of the involvement that they've had in my life and with my children. I don't think they're out to do some good because a lot of the time the good they do is nothing. They don't do any good. Like it's next to nil. They try to do stuff for the sake of the family or you know, I can understand in an abusive situation, yeah, or sexual exploitation or whatever you call it. Yeah, that's a reason to get involved. But they did not help me in any way as far as going, telling me what the resources were for me at the time, for counselling, for addictions. All they said was that I had to do this, this, and if I didn't do it I wouldn't get my kid. And they didn't give me any support as far as somebody to talk to when I was all upset about not taking my daughter home with me after the hospital…They didn't really give me a reason [why I couldn't see her]. It was just, and I was so intimidated by them to begin with I didn't even bother asking why.

A significant number of the children live outside of the care of their mothers. This has made women apprehensive about being involved with CFS and any other service providers they feel will report them to CFS. This has resulted in pregnant women not accessing prenatal care because they are afraid that CFS will find out they are pregnant, and find a way to apprehend their baby at birth.

One of the main reasons children were removed from the care of women was because of substance misuse. Of the 52 women who had children removed from their care, 43 reported that CFS based its decision on the woman's substance misuse. Of those 43 women, 41 reported that they increased their use of substances after their children were apprehended. Some of these women were pregnant at the time.

Throughout this study, women emphasized repeatedly their desire to parent their children well. Having a problem with substance misuse was one of the main barriers that prevented women from accomplishing this goal. For CFS workers, heavy caseloads made providing support services for women whose children had been apprehended very difficult. Concern for the well-being of the woman's children, as well as fulfilling the mandate of CFS, meant that workers were reluctant to return children to the care of biological mothers without clear evidence that the woman had addressed her substance abuse problems. In the busy schedules of CFS workers, clear evidence was usually demonstrated by a woman attending a long-term (over 30 days) residential addiction treatment program and taking a parenting course.

KEY RECOMMENDATION 42: Recognizing the central role of Child and Family Services agencies in the lives of women with substance abuse problems whose children have been apprehended or will be apprehended at birth, that Manitoba Health, work collaboratively with CFS and addiction treatment programs, to find ways in which support services and treatment programs can provide meaningful service options for women when an apprehension order has been made. These service options should include:

a. intensive, supportive and non-judgmental support services, including grief counselling and referral to treatment programs, for women directly following apprehension of their children;
b. preparation for women to enter addiction treatment programs to ensure that they will gain the greatest benefit from the program;
c. formal written agreements between CFS and women as to the requirements which must be met in order for a woman's children to be returned to her care, or for an apprehension order to be lifted;
d. regular visitation schedules for women and their children during the periods of apprehension; and
e. the development of support services for women and their children once addiction treatment is completed and children are returned to the care of the mother.
f. training for CFS workers in addiction prevention and treatment.

B. ADDICTION TREATMENT

TABLE 17: PARTICIPANTS IN TREATMENT	**Winnipeg (N=41)**	**Thompson (N=18)**	**The Pas (N=15)**	**Total (N=74)**
Number of participants in treatment when interviewed	8 (20%)	3 (17%)	3 (20%)	**14 (19%)**
Number of participants who had been in addiction treatment	36 (88%)	9 (50%)	13 (87%)	**58 (78%)**
Average number of times in addiction treatment	3	1	2	**2**
Pregnant while in treatment	15 (37%)	1 (6%)	0	**16 (22%)**
Number of women who have tried to access addiction treatment	40 (98%)	12 (67%)	14 (93%)	**66 (89%)**
Number of women who have never tried to access treatment	1 (2%)	6 (33%)	1 (7%)	**8 (11%)**

The aim of this project was to examine the service needs of pregnant women with problems of addiction, specifically with respect to addiction treatment services. The majority of women who seek addiction treatment in Manitoba are between the ages of 15 and 45, which are the childbearing years. According to service providers, pregnant women have increasingly sought addiction treatment over the past five years in Manitoba. However, while it is not known how many pregnant women access addiction treatment per year, this study found that women in Manitoba tend not to seek addiction treatment services when pregnant. Statistics from the AFM show that 4% of the women who participated in the AFM's residential and non-residential programs during the period of April 1999 to March 2000 identified themselves as being pregnant at the time of treatment. This strongly indicates a serious health concern. In all, of the 516 women entered addiction treatment (314 residential, 202 non-residential) provided by the AFM during this period, 19 were pregnant. It can be reasonably assumed that a number of women who were unwilling or afraid to disclose their pregnancies were also among this group, meaning that the percentage of women who are pregnant when accessing treatment is probably in the range of 5 to 8%.

Among the 74 women interviewed for this project, 14 (19%) were currently involved with a residential or outpatient/day addiction treatment service. Many others were attending self-help or support groups such as Alcoholics Anonymous

(AA) or Narcotics Anonymous (NA). Fifty-eight women (78%) had been in residential or outpatient/day addiction treatment an average of two times at some point in their lives. Sixteen women (22%) reported being in an addiction program, either residential or outpatient, when pregnant.

1. Reasons Why Women Enter Addiction Treatment

TABLE 18: PARTICIPANTS' REASONS FOR SEEKING TREATMENT	**Winnipeg (N=41)**	**Thompson (N=18)**	**The Pas (N=15)**	**Total (N=74)**
Number of women who had been in an addiction treatment program	36 (88%)	9 (50%)	13 (87%)	**58 (78%)**
REASON: FORCED OR COERCED				
CFS threatened to apprehend her baby at birth unless she goes to a treatment program during her pregnancy ("birth alert")	7 (19%)	0	0	**7 (12%)**
To regain custody of children who are in the care of CFS	20 (56%)	3 (33%)	7 (54%)	**30 (52%)**
Legal ward of CFS; forced to go to addiction treatment by them	1 (3%)	1 (11%)	1 (8%)	**3 (5%)**
Legally mandated as part of court sentence	3 (8%)	0	1 (8%)	**4 (7%)**
Other people thought she should go	4 (11%)	2 (22%)	0	**6 (10%)**
Ultimatum given by husband	1 (3%)	0	0	**1 (2%)**
To regain custody of children who are in the care of her ex-husband/partner	1 (3%)	0	0	**1 (2%)**
Cut off social assistance because of substance use	1 (3%)	0	0	**1 (2%)**
Parents put her in treatment	1 (3%)	0	1 (8%)	**1 (2%)**
To keep her room at transition house	1 (3%)	0	0	**1 (2%)**
Problems in school; she had to go to a treatment program before her school would allow her to continue	1 (3%)	1 (11%)	0	**2 (3%)**
To get her job back	0	1 (11%)	0	**1 (2%)**
Total number of women in treatment to regain custody of children from CFS, or to avoid apprehension of baby at birth	21 (60%)	3 (33%)	7 (54%)	31 (53%)
Total number of women who were forced or coerced into treatment	26 (74%)	8 (89%)	9 (69%)	43 (74%)
REASON: CHOICE MADE BY WOMAN				
Wanted to change her life	13 (36%)	4 (44%)	3 (23%)	**20 (34%**
Because she was pregnant	6 (17%)	0	0	**6 (10%)**
For her children	2 (6%)	0	0	**2 (5%)**
Health compromised by continuous use	1 (3%)	0	0	**1 (2%)**

The reasons that women gave for entering addiction treatment varied, but they can be divided roughly into two categories. The first category is when a woman enters addiction treatment because she is forced or coerced. This can be as formal as a court judgement that mandates her into treatment, or an ultimatum from a family member. The second category is when a woman feels that she freely chooses to enter treatment for a reason that is meaningful to her. The distinction between these two categories is often blurred. For example, a woman may enter treatment to make changes in her life because she is pregnant. At the same time, CFS may tell her that if she does not enter a treatment program it will apprehend her baby at birth. While the result of either reason may be that the woman ends up in treatment, the underlying motivation driving the woman to enter treatment is very different, and may have either a negative or positive influence on how well she does in treatment. As one woman explained, her motivation to go to a treatment program was based on multiple factors:

> That's why I came back here. Because I was ready to do it for myself. Because I was very depressed that I didn't have my children with me and I was also depressed because they were going to take away my son. And I couldn't stand the thought of that. So I came in here because I wanted to get them back and change. I was just so depressed that I couldn't handle it anymore.

a. Force or Coercion

TABLE 19: NUMBER OF PARTICIPANTS WHO HAVE BEEN FORCED OR COERCED INTO TREATMENT	**Winnipeg (N=41)**	**Thompson (N=18)**	**The Pas (N=15)**	**Total (N=74)**
Total number of women in treatment in order to regain custody of children from CFS or to avoid apprehension of baby at birth by CFS	21 (60%)	3 (33%)	7 (54%)	**31 (53%)**
Total number of women who were forced or coerced into treatment	26 (74%)	8 (89%)	9 (69%)	**43 (74%)**

According to addiction specialists who were interviewed for this project, when clients are forced or coerced into treatment, it is more likely that they will have difficulty in the program. As well, they will have a greater chance of either dropping out of treatment or of being asked to leave the program because they have not complied with the rules governing the program and/or facility. Even when a pregnant woman enters treatment to decrease the risk of harm to the fetus, there is a greater chance she will not complete the program than if she enters treatment because she feels she wants to improve her own health and well-being. Many women, especially those who are entering treatment for the first time, have little or no preparation for participating in treatment programs. Women reported being afraid of or intimidated by treatment programs, particularly those that have reputations for being hard or difficult. For some women, this fear or intimidation continued throughout the various stages of treatment, and as a result, they left before completing the program.

Women who are forced or coerced into treatment usually do not see treatment as much more than a means to an end. Even though many women in this situation would say that addiction treatment is a valuable and positive way for people to deal with substance misuse, they do not necessarily relate this to their own lives. In many cases, women are so preoccupied with filling the immediate requirements of social assistance, the courts, or CFS, that they do not focus on their substance misuse problems while in treatment. The reality is that they perceive the situation as a battle between them and an oppressive agency in which they have only one option, and that is to comply with the requirements. The fact that the requirements, such as attending addiction treatment, are meant to improve the overall situation for the woman does not necessarily mean that women experience or view the situation as such. For example, one woman explained that the reason she entered treatment when pregnant was simply because she was cut off social assistance and felt that she had no other option but to comply with the wishes of her social worker. During this process, she did not feel supported or motivated by the service provider. For her, it was simply a matter of meeting the requirements set out by the agency:

> **Q:** Did they make you go into a treatment program?
> **A:** No, I went on my own. 'Cause I got cut off of welfare.

> **Q:** Why were you cut off?
> **A:** 'Cause I was sniffing and they cut me off so I had to go to a program to get back on...Because I went to the office smelling like sniff and alcohol and they said they can't help me out anymore until I take some help. So I said, "Okay, I'll go to a program." And I went for five weeks. Came back, the next day I got back on welfare. I had to show them a certificate that I did the program. And I showed them that diploma and then they said, "Alright, looks like you did your program." I went for five weeks and they put me back on assistance.

Unfortunately, in cases such as this, it is not always clear whether the motivation of the agency is to improve the quality of life of the woman, or simply to make sure that "undeserving" women do not receive benefits from the state. Because some service providers, such as government social workers, carry such large caseloads, strategies to help women improve their quality of life are reduced to a checklist of requirements that women must complete to gain the benefit that they seek.

Of the 16 reasons given by women for why they entered addiction treatment, four were based on some form of formally-mandated treatment by the courts or CFS, and eight were circumstances where women were forced or coerced by partners, family, employers, social assistance, or school. Two reasons were based on the welfare of the woman's children, and one on the health of the woman. A final reason was based on the desire of some women to change their life circumstances.

The reason most often given by women for entering addiction treatment was to regain custody of children that had been placed in the care of a CFS agency. Of the 58 women who participated in addiction treatment, 30 (52%) had done so to regain custody of children. Among the women who entered treatment, seven (12%) reported entering a treatment program when pregnant due to a "birth alert" being placed on them by CFS. These two numbers reflect the significant role that Child and Family Services agencies play in a woman's decision to enter an addiction program. One woman explained:

> ...I felt like I was doing it to please them [CFS] and not myself because I was being forced, so that's why it didn't work out for me.
> **Q:** Did you receive any benefit from the program even though you were forced to go there?
> **A:** Some of it, yeah. I got some benefit but then I just thought, "Oh, they're forcing me in here, why should I quit drinking for them?"

Another woman explained her struggle to get her children back:

> **Q:** And so they made you go to treatment in order to get your children back?
> **A:** Yeah.
> **Q:** And so then what happened?
> **A:** So I went through treatment three times. And each time I went through I'd always get drunk. I'd always use and I'd always get kicked out because when you're there you're not suppose to use or drink.
> **Q:** And then what would happen?
> **A:** I wouldn't get my kids back.

For women who felt they were coerced into treatment by CFS, their experience in accessing treatment was not necessarily easy or quick. As one pregnant woman explained, her past decision to leave treatment caused problems for her when she wanted to return. This woman—even though she was pregnant—did not receive the full support of CFS and social assistance because they felt that she would not complete the treatment program. The threat of a CFS "birth alert" and a permanent custody order for her other children meant that the woman had to choose between losing custody of her children permanently, or walking away from her home and leaving all the family's personal belongings to enter treatment a second time. Once in treatment, she had to prove to CFS that she should be allowed to parent the child she was expecting and her other children who were already in foster care. She also had to prepare to move out of treatment into a home with her new baby and children, despite having lost all the family's belongings:

> **Q:** In order to go into treatment what kinds of things did you have to prepare?
> **A:** I had to get my stuff in storage so the City [welfare] paid for that for a few months. And then when I left treatment I took my stuff out of there.

> And when I was coming back to treatment they wouldn't put my stuff back in storage because they talked to CFS and they said that I was known for not completing the program. So they didn't want to put my stuff back in storage. This is what the CFS worker told them so welfare wouldn't do it for me.
> **Q:** So what happened to your stuff?
> **A:** I practically lost everything that I have. Even my kids' clothes. All my furniture, everything, it's all gone.
> **Q:** Did somebody just take it?
> **A:** I just left it. I had to leave it, everything. I had no money to move my stuff. Nowhere to put it. I lost everything.
> **Q:** Even though some of the stuff belonged to your children as well? Was there no one there on their behalf?
> **A:** No. Like CFS, I thought that they would put my stuff in storage if I went to the program. But my CFS worker kept saying no we don't do that…I don't know exactly what my CFS worker thinks, but my welfare worker told me that she [the CFS worker] said that I was known to not complete these programs and they're not going to pay for my storage because of that. But if CFS would have said, "Yes, we're behind her all the way to go to treatment the second time," then the welfare would have put my stuff in storage. And that's what they said to me. CFS is not behind you on this. They are not supporting that you go there.
> **Q:** Even though they wanted you to go to treatment?
> **A:** Yeah. And my CFS worker was saying that she wasn't supportive of me and all this stuff.
> **Q:** And at the same time they had permanent custody of your children?
> **A:** No, they were going for one.
> **Q:** And did they know that you were pregnant ?
> **A:** Yeah, they already found out.

b. Freely Choosing Treatment

Data from this study show that women who were forced or coerced to go to an addiction treatment program were usually younger than those women who chose to go to treatment because they wanted to do so. Women over the age of 25 were more likely to enter treatment in order to change their lives. Because many of them had been in treatment a number of times previously, they were better prepared for what the treatment program would be like, and therefore, it was more likely that they would complete the program. As one woman explained:

> I started to get more knowledge out each time I went back. 'Cause each time I went back I wanted help even more. They said, "You'll get out of it what you put into it."

As they become older, women generally experience treatment in a more positive way. But these women also have a longer history of substance abuse and its negative consequences (such as losing custody of children) that accompany substance abuse. Older women are more likely to have children who are permanent wards of CFS, and/or to have had a tubal ligation. Many of these women simply do not see a meaningful reason to seek addiction treatment. With no possibility of gaining custody of their children, and/or having more children, the health and well-being of these women can decrease significantly in a very short period due to their substance abuse.[1] These women typically carry extreme guilt and shame, which further fuels their substance misuse. For example, one woman in the study who reported sniffing solvents daily explained why she chose to have a tubal ligation:

> **Q:** Do you think you will have more children?
> **A:** Not after what I did to my little girl. What I put her through. I got my tubes tied 'cause I didn't want to put more pain on my kids. I really punished my girl lots. I put her through a lot.

This woman, whose health was seriously compromised, had no future plans to seek help for her addiction even though she had been to addiction treatment programs and felt they were valuable. Because she no longer had custody of her children and could not become pregnant again, there was no pressing reason for service providers to encourage her to enter treatment. However, in discussions with addiction specialists, many agreed that this woman, in all likelihood, would die at an early age directly or indirectly from her substance misuse.

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[1] This is not to suggest that children are the only motivating factor for women to stop using substances, but to highlight that for many women in this study, not having their children in their care, along with the knowledge that they would never regain custody of their children or have other children, placed them at extreme risk of continued heavy substance abuse.

Data collected for this project show that pregnancy motivated women to decrease or stop their substances use. It was also a time when special services became available to women, and when service providers were particularly motivated to assist women in accessing help for their substance misuse. However, data also showed that women who are pregnant typically do not seek addiction treatment. Some who do seek it do so because they are coerced by CFS, but others do so because they see treatment programs—specifically residential programs—as places where they can find security and support. One woman who was interviewed reported that the reason she decided to go to treatment when she was pregnant was because she would have good food and be "looked after" while in the program.

Both women and service providers agreed that it is better if women enter treatment because they choose to do so. Of the 58 women who entered treatment, 20 (34%) reported that they did so on one or more occasions because they wanted to change their lives. These women typically had a key person, usually a service provider, with whom they had a long-term, supportive relationships, and who were able to help them access an addiction treatment program. While some may argue that there is a fine line between support and coercion, the women interviewed felt that when they were working *with* a service provider to access treatment rather than being given an ultimatum, they were much more willing to engage positively in the treatment experience. All women reported that this occurred for them in an environment where they felt supported, respected and not judged by service providers. One woman explained how a worker at a drop-in centre she regularly visited kept encouraging her to go to treatment. The woman finally decided to enter treatment when she became pregnant. Even though she began to use after her baby was born and she had finished the treatment program, her overall experience was very positive. The worker continued to encourage her to seek further help by reinforcing a positive outcome of her treatment (her baby being born healthy), rather than focusing on the fact that she had relapsed and was currently using:

> ...I went to a program with her in my belly. If I didn't go she wouldn't have been normal, I guess. But then when she went to the hospital...they said, "Your baby is okay, there's nothing wrong with her. When she gets older there's going to be nothing wrong with her."
> **Q:** And how did that make you feel?
> **A:** It makes me feel good...that's what [my worker] said to me: "You've given your daughter a chance to have a good life by going to the program."

The influence of family and friends in a woman's decision to enter treatment can be both positive and negative. While some women reported that they were forced or coerced by partners or family members to seek treatment, it was more likely that the woman's partner or family would not want her to go to treatment, usually because of their own substance abuse problems, or because they were afraid of the stigma this would bring to the woman and/or to them. Women interviewed for this study typically had limited positive social support networks. Most women had few people to whom they could talk or rely upon. Women reported that their substance misuse problems often alienated them from the people in their lives who were supportive of them seeking addiction treatment.

2. Barriers to Accessing Addiction Treatment

TABLE 20: PARTICIPANTS WHO REPORTED BARRIERS WHEN ACCESSING TREATMENT	Number	Percentage
Winnipeg (N=40)	36	90%
Thompson (N=12)	10	83%
The Pas (N=14)	13	93%

TOTAL (N=66)	**59**	**89%**

Despite efforts in Manitoba to make addiction treatment available to women, barriers still exist which prevent women from accessing help to deal with their substance misuse problems. While service providers generally believed that pregnant women are accessing treatment more easily than they did two or three years ago, many of these barriers still apply for pregnant women. Of the 66 women who reported trying to access treatment, 59 (89%) experienced barriers that prevented them from doing so at one time or another. These barriers[2] can be divided roughly into six categories: psychological barriers; barriers related to a woman's children; barriers related to social support networks; barriers related to socio-geographic factors; barriers related to stigma; and barriers related to treatment programs themselves.

a. Psychological Barriers

Consumers reported several barriers when accessing addiction treatment that were created by their personal feelings about their substance use and/or about addiction treatment programs. In some cases, women refused to acknowledge their substance misuse despite the fact that it caused significant problems in their lives. Part of this denial was to refuse to attend addiction treatment programs or self-help services. For other women, low self-esteem, pride, and/or fear became barriers to treatment. The women interviewed identified the following barriers:

denial of having a substance misuse problem;
not ready to quit using substances;
did not want to go because she was pregnant;
thought that she could quit on her own without treatment;
gave up trying to get children back from CFS and to change her life;
did not feel that her substance misuse could harm her unborn baby;
too much pride to enter treatment;
fear of stigma if she admitted being pregnant and addicted;
fear, guilt, and shame that prevented her from telling people that she needed help;
afraid of the shame and stigma it would bring to her and her family;
afraid to try new things;
never referred to treatment by people she trusted;
fear that if it became known that she used illicit drugs, she would get in trouble with the law and/or lose custody of her child(ren);
afraid to lose her boyfriend if she went into treatment;
felt she was too young to need addiction treatment;
fear of going into an addiction treatment program;
afraid to go through detoxification;
the available program has a negative reputation and there are no other options available in her community;
no treatment programs for women, does not want to go to a mixed (men and women) treatment program;
does not like the philosophies of the available treatment programs;
fear of male clients in the program she needs or wants to access who are just out of jail;
past failure in treatment and does not want to go back; and
has nothing in common with other clients at treatment centre.

For many women, being afraid to attend an addiction treatment program for one reason or another played a major role in why they did not access treatment. The basis for these fears was often due to women not having enough positive support from key people in their lives, such as family, friends and service providers. Many women were fearful of the stigma and shame that going to treatment would bring to them, particularly if they were pregnant. They were afraid that being labeled as an "alcoholic" or an "addict" would have negative repercussions for them and their families. As one woman explained:

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[2] It should be noted that these categories overlap considerably, and in some cases, are interchangeable.

> ...Actually, I do call it an addiction because I believe an addiction is when you do something and you can't stop doing it whether it be eating chocolate, alcohol, drugs, whatever. And I know that when I drink alcohol I can't stop until I either pass out or black out or something like that. So I do have a problem. The fact is that I can't bring myself to go to treatment here and say, "Listen I have a problem." I mean, I'm respected at work. All the management want me in all their areas and I present a good picture. I haven't missed a day. I don't let it affect my work.
> **Q:** And if you admitted having an addiction, what do you think would happen?
> **A:** Probably it would destroy me professionally and personally...because of that label, when people talk, "Oh well, there's the alcoholic." And I can't afford that.

One pregnant woman explained her fear of being caught using marijuana:

> Like, because of my mom's use with alcohol, like I said, I went and reported my mother a few times. And like now, I'm scared because I'm smoking marijuana and if someone finds out then at any second I'll have a social worker and a cop standing at my door telling me that I just lost custody of my kids because of the drug use. And like, every time I light up a joint or light anything, that's the first thing that comes to my mind are my kids. But I don't use it for myself. I use it to try and relax myself or to try and calm down. And to try and stay sane. And like, a lot of people are saying that that's just an excuse, like you don't need it. Well, if you've been doing drugs for the past 15 years, you'd realize that I do need it when everything is falling out of place for me.

For many women, their fears of CFS kept them from accessing treatment. As one woman explained after being asked if she had the opportunity to go to treatment:

> Oh, yeah. There was lots of opportunity. But like I said I didn't want to lose my kids. I was so scared of the initial, okay if I trust these people [CFS], I go, right, what's going to happen? What if they don't think I'm good enough? What if they think, "Oh she did this, she did that?" I was scared of Child and Family. I've always been scared because when I was eleven I got taken away for nothing.

Other women reported that they did not feel their substance misuse had enough of a negative impact in their lives, including during the times when they were pregnant, to be called a problem and/or to warrant going to a treatment program. This was particularly true for the younger women in the study and for women from smaller communities. One young woman stated:

> ...my mother drank with all of us and all of us are healthy. I thought, ah, it's just BS what they say about alcohol...And so I never thought it could really harm a baby.

Another woman explained how she did not understand her substance misuse as a serious problem because she felt she was too young to be an alcoholic. She felt she had no one to talk to about the abuse she had experienced as a child and an adult and how it contributed to her use:

> Realizing I'm an alcoholic, I have a drinking problem, and trying to understand that I'm an alcoholic and I feel too young to be an alcoholic. All this stuff has happened to me...I really didn't know who to talk to about it. That was when I was still pregnant with my last daughter.

Other women felt that if they were going to stop using substances, then they would quit on their own without the help of an addiction treatment service. This was often the case for women who had children in their care or who were employed, both of which were priorities that women placed above their need for addiction treatment, and which involved relationships that could be jeopardized if they admitted to having a problem with substance misuse.

For some women, feelings of helplessness and hopelessness that they could not change their life circumstances prevented them from accessing addiction treatment. For example, one woman explained how she felt when CFS apprehended her children early in her pregnancy:

> I just gave up and I didn't care about anything or

> anybody. As long as I had my drug I was okay. But I didn't care that Child and Family saw that anymore. Like, it got to the point where I was wishing I would just die, OD or something. 'Cause like, after awhile the drugs were not even helping to take away the pain. That's how low I went.

For other women, the perception of what addiction treatment would be like prevented them from trying to access treatment. These women believed that they would be unable or unwilling to cope with the conditions under which treatment would be provided to them (such as strict rules, attending group sessions with men, opening up during counselling and group sessions about past sexual abuse). During interviews, women referred to their own or others' past negative experiences in treatment. Even though Manitoba has both long-term and short-term programs, women felt their choice of treatment services was limited because only a few residential programs allowed women to bring their children with them, and outpatient/day programs did not provide child care services. Women felt that they had limited options for woman-centred treatment. This was particularly true for women who tried to access treatment outside of Winnipeg.

Data from this study show that the perception women have about their substance use and about addiction treatment prevents them from seeking help. In the majority of cases, barriers within a woman herself are not the sole reasons why a woman is unable to access addiction treatment. Other barriers related to her children, the environment in which she lives, and to the treatment services offered are intertwined in complex ways that make the accessibility of treatment virtually impossible for some women.

b. Barriers Related to a Woman's Children

Women reported several barriers to treatment related to their children. In the experience of these women, the barriers preventing them from accessing addiction treatment increased significantly when they had children in their care. This was supported by interviews with service providers who refer and/or help women access addiction treatment services. Barriers related to a woman's children included:

fear that her children will be apprehended by CFS if she admits needing treatment;
fear that if she places her children in temporary care with CFS while she is in treatment, the children will not be returned to her after she completes treatment;
fear that if she places her children in temporary care and then cannot complete addiction treatment, CFS will not return her children to her care;
fear that to gain custody of her child(ren), the father or a relative will use her treatment for addiction as a way to discredit her as a mother;
fear that she will not complete treatment if her children are not with her;
fear that she will be seen as a "bad mother" if she admits to needing help for a substance misuse problem;
fear that her children will have the same negative experience she had while in a foster family;
fear of leaving her children in the care of someone else while she is in treatment;
having no child care for her children while she is in treatment;
her children do not want her to go away, but there are no treatment services in her community;
there is no addiction treatment offered in her community so that she can attend treatment and her children can stay at home and attend school; and
that even if she goes to treatment, she does not have a chance of getting her children back from CFS.

Barriers related to children that prevent women from accessing addiction treatment were reported more often than barriers in the other three categories. Women frequently reported being fearful of having their children apprehended or of having a "birth alert" placed on them if they admitted to having a problem with substance misuse or needing addiction treatment. In most cases, women based their decision not to go to treatment on similar experiences that had either happened to them or someone they knew. For example, one woman stated:

> All the actions were my choice. 'Cause the support was there and I knew where to seek the help. 'Cause I was so scared of apprehension. 'Cause you hear it all the time that I just thought if you brush the dirt under the carpet no one will see it. At one point someone is going to kick that carpet and it's going to come out…I find that just from the personal experience of other people I've heard of, which is why I lied throughout my pregnancy. They [CFS] only see it one way. They say they want what's best for the kid, but a lot of mothers, well, there are some women that deliver their babies and they're still using, you know. I think they should offer more drug programs. They should offer more programs where mothers can be with the baby. Where CFS don't have to take away the baby. So I mean, why, if the mother is going to be in a program bettering herself, why should the baby be taken away?

Another woman explained the power that she felt CFS had over her:

> ...They [CFS] had my life in the palm of their hand and they could have squished me or thrown me away or taken my daughter forever for all I know. I didn't dare contradict what they were saying or stand up to them because they had my daughter and I didn't know.
> **Q:** So as the mother you feel you lose all your rights?
> **A:** You do. If CFS gets involved you can pretty much kiss your kids goodbye.

Women also reported that they were reluctant to talk to service providers about accessing addiction treatment because they were afraid that these service providers would then report them to CFS. This was particularly true in women's perceptions of physicians or service providers who were involved with prenatal programs and services. One woman explained:

> I didn't tell them what I really wanted to tell them because I look at them and they all work with Child and Family. I don't know who doesn't and who does. And they might say something to them.

Another woman explained her decision not to tell her doctor about her use:

> **Q:** Did the doctor ask you about your use?
> **A:** No, they didn't ask me at all. Well, they did ask me but I lied to them. I'm not going to tell them because CFS would have got called. And then he would have been taken away because I didn't do drugs but I drank. And they don't want that. 'Cause I'm a good mom. I'm a really good mom. Anywhere you go, where I go, they'll tell you that.

One woman explained that when she was pregnant she became isolated from the service providers who supported her because she feared CFS would find out and take her baby:

> I first went to this doctor and I didn't get a very good feeling from her because at that time I had tried shooting up a few times and I had told her. And instead of her being a counselor, she basically ridiculed me. Told me I was stupid and crazy for doing that. "Aren't you thinking of that baby?"…So I kind of backed off from doctors for a few months…I never told anybody because I was so worried about getting my baby taken away. I never told the obstetrician that I was using. The hospital found out because my counselor told them. She warned me ahead of time…I kind of backed off, away from her when she said that about me. I just wanted to cut myself away from her. I was so scared about CFS getting involved and taking my baby. But that didn't stop me from using. Every day I'd tell myself this is it.

In these cases, important opportunities to encourage and support pregnant women to access services for their substance misuse are lost because women do not feel that they can trust service providers. This mistrust is supported by the fact that service providers who suspect child abuse or child neglect are legally obligated to report the mothers to CFS. Many service providers, despite the Supreme Court of Canada ruling in the "*G*" case, have extended their reporting to include pregnant women who use substances. This has resulted in CFS placing "birth alerts" on pregnant women who have been identified in this way. This means that rather than being mandated into treatment, women are given an ultimatum that if they do not enter an addiction treatment program, then CFS will apprehend their babies at birth. If women have other children in their care, CFS also uses the threat of apprehension as a way to further coerce them into addiction treatment.[3]

While the motivation of service providers in this type of situation is to reduce the risk of harm to the fetus, information gathered during this project indicates that the reaction of women to the threat of "birth alerts" and child apprehensions is to distance themselves from service providers. In some cases, women reported leaving their homes and travelling to other parts of the province or out of province to avoid a "birth alert." Many women also reported concealing their pregnancies for months from their social workers so that they could avoid CFS' involvement as long as possible. Service providers, particularly those outside of Winnipeg, found that women would not access services for prenatal support if the programs were located in the same building as CFS. As a result of the mistrust pregnant women had of service providers, many ended up not accessing key services that could benefit them during their pregnancies, help them reduce their substance use, and help them access addiction treatment. As one woman stated, she and her partner spent the period of her pregnancy trying to avoid CFS:

> They [CFS] came and saw me when they found out I was pregnant. And they asked me if I was still drinking and doing drugs. I said, "Once in a while," and I was already two and a half months at the time and they said, "Maybe you should have an abortion." They asked me to have an abortion and I said, "No." And then we were trying to get away from them. They kept on bothering us. And then when I had my son they came and saw me at the hospital. And they asked me if I was drinking and doing drugs still. I said, "No." They said, "Well, we're going to find out anyway because if the baby comes out with FAS then we'll find out and we're going to apprehend the baby." So they did the blood test and everything, and there was nothing wrong with him. But I did drink and I'm really amazed that he didn't have anything like that. 'Cause I drank and did drugs until I was four or five months pregnant.

The events around hospital apprehensions of newborn babies born to women who are known to have substance misuse problems are very influential in determining whether a woman will enter addiction treatment. Data from this project show that the majority of women interviewed would be more willing to go to an addiction treatment program after giving birth than during a pregnancy. Women reported that giving birth to a baby was when they felt the most compelled to change their life circumstances. Many women felt that their newborn babies were key motivators for them to want to stop using substances. As one woman explained:

> If I wouldn't have got pregnant I don't think I would have quit. My baby was my saviour. The pregnancy alone didn't force me to quit. It was after.

For those women who had a baby apprehended at the hospital, the circumstances around the birth (the attitude and actions of the hospital staff, CFS workers, family members and male partners) greatly influenced whether a woman entered treatment and her attitude toward the treatment program. For example, one woman explained the events around the apprehension of her baby at the hospital. She was told by CFS that in order to get her baby back she would not only have to go to treatment, but also the treatment program had to be a long-term residential program. The woman was left with one option available to her in the geographical area where she lived. Because she was no longer pregnant, there was no priority given to admit her to the treatment centre, and she was placed on the regular waiting list:

> ...The doctors at the hospital told my CFS worker, and explained to them that my baby was having withdrawals...and they apprehended my baby from the hospital. And then they apprehended my

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[3] This is not to suggest that CFS workers are purposely pitting themselves against women. Rather, they are genuinely concerned for health of the fetus and that of the woman's other children. Apprehension of children is a necessary measure at certain times, as is the placement of a "birth alert." The point here is to stress the perceptions and responses of women.

> other kids….My baby was all ready to come home, then they just came walking in and told me, "We're taking your baby. He's under apprehension."
> **Q:** And so how did that make you feel? What happened at that point in time?
> **A:** I was really upset. And I knew that it was my fault too. It really hurt a lot for them to apprehend my baby from the hospital.
> **Q:** Was there anybody there for you?
> **A:** My common-law was with me at the time.
> **Q:** And did CFS suggest at that time that you go into an addiction treatment program?
> **A:** Yeah. That's what they told me and my common-law. They said, "The only way you'll get your kids back is if you get healthy yourself. Get some treatment done…."
> **Q:** How did you feel about their suggestion? Was it supportive of you?
> **A:** No, it was just straight out, "We're taking the kids. You get yourself help and that's it."
> **Q:** So then what happened for you?
> **A:** I just left the hospital. I just started back with my using.
> **Q:** And how did you see your situation at that time?
> **A:** I just saw it as my children are gone now.
> **Q:** And did you think that you could get them back?
> **A:** I didn't think I could get them back…They just told me that I had to go to a treatment program. And they said it had to be a long-term treatment program.

Another woman explained similar circumstances around the birth and subsequent apprehension of her baby, specifically the lack of support she had from her family and the CFS worker:

> **Q:** What was done to help you?
> **A:** Nothing. Not my family anyway.
> **Q:** What did social services do to help you?
> **A:** Nothing.
> **Q:** Did they connect you up with any addiction programs?
> **A:** They only gave me one visit [with my baby] and then that worker canceled my visits.
> **Q:** With the baby?
> **A:** Yeah.
> **Q:** And so did they say to you, "Okay, would you like to go into an addiction treatment program?" Did they suggest that you go, or did they hook you up with any services?
> **A:** They don't suggest to you, they order you to.
> **Q:** So how can they order you to go in?
> **A:** Like, they use your kids. It feels like blackmail. If you don't go into treatment you are not going to see your kids.

A third woman, who was pregnant during the time of the interview, explained the events around the births of two of her older children:

> **Q:** What happened to you when they apprehended your baby?
> **A:** I didn't care.
> **Q:** Was there any support there for you?
> **A:** No.
> **Q:** At that time did anyone say to you that you should go to an addiction treatment program to get your baby back?
> **A:** No, right away they said, "Permanent order."
> **Q:** I'm interested in how women feel when they have just given birth in the hospital and they [CFS] apprehend their baby.
> **A:** With her [the baby], I just gave her up. I left the next day. I didn't bother staying. I left the very next day. I felt that I was strong enough to just leave her there and I was thinking that if I would have stayed a couple more days I would have got close to her and I wouldn't want to leave her. So the very next day I thought just leave her. So I just left.
> **Q:** So did anyone at all contact you and ask you if you were okay? Or if you needed any support at all?
> **A:** No, well, Child and Family started calling me and wanted to know if I wanted to visit. But when I found out that I really harmed her when she was inside of me, well, they're not going to give her back. So when they said the permanent order was on her, then I said, "Okay, whatever." After I had her they said they were going to go for a permanent on all three of them [her other children who were in the care of CFS]…
> **Q:** And so even though she wasn't in your care you kept getting reports about her?
> **A:** Yeah, I was visiting her up until she was maybe six months...
> **Q:** How did you feel about them saying that your use had caused problems for your child?
> **A:** How did I feel? I felt really bad. I thought I fucked this kid for life. She's probably going to get

older and maybe she'll know who I am. Maybe she won't understand anything. But if she does then she'll hate me for what I did to her. And I just thought I wasn't going to have anymore kids. But I ended up having another one after that…The best thing I ever did for her was to give her away. I think, look, after that I was still on drugs. Where would she be today? She probably would have been more fucked up than she is.
Q: So then for you, what happened in your life?
A: It was really mixed up after I had her. I broke up with my boyfriend and we were off and on.
Q: So after you broke up with your boyfriend what happened?
A: I got pregnant with somebody else's kid.
Q: What kind of support did you have?
A: I didn't have any support. Nothing.
Q: In terms of family and friends?
A: No, my parents were really mad at me.
Q: So you weren't seeing your parents at all?
A: No, I locked myself away for about six months. I didn't have no friends. I didn't have nothing. I just moved into a hotel. Went out prostituting. I sold myself. And I locked myself away for six months. I'd just go out to work, get my drugs, go out to work, get my drugs. I did that for six months 'til finally I went down to like 92 pounds...
Q: So you were still living in the hotel when you gave birth to the baby?
A: I almost gave birth at the hotel.
Q: So the day you gave birth were you using?
A: I think I did a shot maybe 20 minutes before I had him.
Q: Did the doctors know that when you went into the hospital?
A: Yeah. Because when he was born they gave him something right away. 'Cause he was badly shaking when he came out. He was withdrawing right away…
Q: Did they take the baby?
A: Yeah. Apprehended him at birth.
Q: Was there any support for you?
A: No.
Q: Did a social worker come and see you and ask you how you were doing?
A: No.
Q: How did you leave the hospital? Did you get up, get dressed and walk out?
A: Yeah.
Q: That was it? Nobody asked you where you were going? Or what you were going to do?
A: No.
Q: So with that baby it was a permanent custody order as well?
A: Actually he was apprehended but I didn't really bother with him. I never visited him. I just gave him up, just like that.
Q: So then you went back to the hotel and you were still working?
A: Yup.
Q: What was it like to go back to the hotel?
A: A very big emptiness. It was bad. Very depressing.
Q: And so did you start using right away again?
A: Yeah.

Although this woman did complete an addiction treatment program during her current pregnancy, she subsequently started using again while pregnant because the courts granted the permanent order on her son.

Women also reported that they were afraid that going to treatment would be used against them by a family member to gain custody of their children. Fox example, one woman reported that after her divorce, her ex-husband used her addiction and the compromised health of one of their children as a way to discredit her as a mother and then to gain custody. Another woman discussed the numerous barriers that presented themselves when she wanted to go to treatment, including threats from her ex-partner that made her afraid that he would try and gain custody of their daughter. After weighing all the issues she decided not to go to treatment:

Q: During this time did anyone suggest that you go to a treatment centre?
A: Oh, yeah.
Q: So you went?
A: No, I was 18 and I was going to go to rehab. At this time I didn't do cocaine, but I was going to go because of my drinking. 'Cause I drank, like, non-stop, but my daughter never saw it. She never ever saw me drinking. I drank when she went to bed or I'd drink when she was gone to her dad's. And um, her dad said "No, if you go to treatment I won't bring her to see you, you tell her you've gone away." My daughter was four. So I told her, "I'm going to Toronto for a little

> while." She just cried, she said, "No, no, don't leave me, don't leave me. Can I come with you?" Because I always take her with me wherever I go. She's like, "Why can't I come with you?" I said, "Well, because mommy's gonna go visit," and I felt awful, like, you know. Like, "Mommy's going to visit and you can't come." She wasn't in school so you know what? I couldn't do it. She cried, "Please don't go." So I didn't go. And then I just said, "Forget it." And then I was thinking about it again and I thought, "No, he [her ex-partner] won't let me see her [when I'm in treatment] or he'll take her from me." It's the only thing that I was worried about...But I know I'm a good mom.

Women also reported that they were fearful of what would happen to their children while they were in residential treatment. Because there are only a few treatment centres which have programs that allow a woman's children to stay with her while she is in treatment, women were forced to put their children in the temporary care of either CFS or in the care of a family member or friend. For women who had been in foster care as children, this was a difficult decision to make because many of them had negative experiences as foster children, or they remembered how they felt when their parents were incapable of properly caring for them and they themselves had to be apprehended. Once in the care of CFS, women feared that the temporary custody order placed on their children would not be lifted or be changed to a permanent order if they could not complete the treatment program. This fear was fueled when the women did not fully understand what their legal rights were in relation to the custody of their children and CFS's mandate.

Several women reported that they did not go to residential treatment because they could not take their children with them. Other women who had tried to access outpatient or day treatment reported that they were prevented from going to treatment because they had no one to care for their children and child care was not offered by the treatment program. Other women reported that they did not go to treatment because their children did not want them to leave home. Some women were prevented from going to treatment because they did not want to disrupt their children's lives by removing them from their schools and home environments to go with them to treatment. This was particularly a problem for women who lived in small remote communities.

Recommendation 43: That Manitoba Health ensure that women who enter residential treatment have safe and accessible child care services provided on site or near to where the woman is receiving treatment in order for the women to feel secure about the safety and care of their children, and to allow the parent/child relationship to continue while mothers are in treatment.

A number of women in the study reported that they felt even if they did go to treatment they would not be given another chance by CFS to parent their children. This was particularly true for Aboriginal women in the study, who based these feelings on their past experiences with CFS either as children or as mothers. Among the 74 women interviewed, it was likelier that an Aboriginal woman would have children in the care of CFS than a non-Aboriginal woman (77% as compared to 50%). It was likelier that the court order concerning the children of an Aboriginal woman would be a permanent rather than a temporary order. One Aboriginal woman recalled how afraid she was when she found out that she was pregnant. She then went on to explain what happened after her son was apprehended by CFS during that pregnancy:

> Like, with this one I didn't want to get my hopes up. Like, I didn't want to start to love this baby because of Child and Family, but I did. It was hard not to after I started feeling the baby...'Cause I told my boyfriend that I don't know if I can handle all that pain again. I might lose another baby.

She went on to state:

> ...and I was pregnant with a baby back then when they took my younger son, the one I did have in my care. They don't know what they do to women when they take their children away...Like, nothing mattered to me anymore and I, like, I drank occasionally. I admit that, but after they took my kids, my son, like, nothing mattered to me anymore. Not even the baby that

> I was carrying. And I started drinking more and started doing cocaine and I started shooting cocaine and I did that right through my pregnancy.….In other words, they took my life away when they took my kids. So they don't know what they are putting women through when they do that.

Circumstances in which children are living in homes where substance misuse occurs are troublesome for service providers and society at large. Extending this concern to pregnant women who are using substances has been a natural extension of this concern, particularly because it is known that substance use can cause irreversible harm to the fetus. Data from this project show that the women who were interviewed share these concerns. None of the women felt that extensive use of substances during pregnancy or when parenting children was not problematic, and in fact, many of the women felt more strongly about the harmful effects this behaviour could have than did some service providers. When women spoke about barriers that prevented them from accessing treatment that were related to their children, they were not saying that problems related to their substance use did not warrant concern, and at times, some type of intervention by service providers.

For the majority of women, the characteristics of the relationship they had with a service provider, not the necessity of the relationship itself, was problematic. Women reported that the nature of their relationships with many service providers, particularly CFS workers, was antagonistic rather than supportive. Because the mandate of CFS is to protect children in Manitoba, they are in a difficult position *vis-à-vis* the mothers of these children. Women often view CFS and related service providers as oppressive and threatening to their families. As a result, the women end up juggling a number of things simultaneously, such as their substance misuse, parenting, relationship problems, and the threat of apprehension by CFS, in an effort to keep their families together. Accessing addiction treatment, in the view of many women, cannot be prioritized if it results in their children being removed from their care. As one woman explained:

> ...I was pregnant with my third and they took her away.
> **Q:** What were the circumstances around her being taken?
> **A:** Because there was too much violence. Too much alcohol. Because my ex used to assault me a lot.
> **Q:** In dealing with CFS, what was your experience with your social workers?
> **A:** They were the enemies. So I never did bother to try and communicate with them. But I know now that they were there to help me. If I would have worked with them maybe things would have been different. But I never did like them.

c. Barriers Related to Social Networks

Women reported several barriers in accessing addiction treatment that were related to their social networks. These included:

> most people in her social network were misusing substances, including her family and/or friends;
> she was dealing with other life crises, such as poverty, relationship problems, and providing for her children, with limited support from those in her social network; therefore addiction treatment was not, or could not, be a priority; and
> opposition from key individuals in her social network, including partner, friends and/or family to her participating in an addiction treatment program.

For the large majority of women, factors related to their social networks played a significant role in why they did not seek or access addiction treatment. Many women reported that they had very few individuals in their support networks who encouraged them to decrease or cease their substance use, even when they were pregnant. Coupled with the daily realities of living in poverty and/or raising children as a single parent meant that addiction treatment was not their first priority. Many of the women reported that in order to participate in treatment they were faced with several challenges, such as arranging storage for their belongings, giving up their housing, and finding transportation to the program. These were tasks for which they felt they had little or no support from individuals in their social networks, including service providers.

Many of the women who were interviewed lived in social environments where most people in their support networks were misusing substances. This, they reported, made it very difficult to take the necessary steps to enter an addiction treatment program. For women living in smaller communities where there was a great deal of substance misuse, it was particularly difficult to access treatment as it meant breaking away from behaviour that had become normalized and accepted by the community.

Relationships with male partners also play a significant role in women not seeking addiction treatment. These were not necessarily situations where men are preventing women from attending treatment (although this does occur on a regular basis), but rather, for some women, ongoing violence and abuse by partners meant that accessing addiction treatment is simply not a priority. These women were likelier to end up accessing shelters rather than addiction treatment programs. Many of the partners of women who were interviewed were heavily involved with substance abuse themselves. Women reported that men often used their addiction as a means to control and manipulate them. One woman explained:

> ...Oh, my self-esteem was so low. I felt like I was worthless. I felt like I was nothing. He put me down and it just felt like I was just a mat that he could just walk all over, wipe his feet off.
> **Q:** Why did you stay?
> **A:** The reason I felt at the time was because he had the connections for the booze. He had the connections for the drugs. And as long as he had the connections I was going to stay no matter what.

Another woman explained that when she was pregnant she worked as a prostitute to support buying drugs for her and her boyfriend:

> …at that time I was living in a car. So that was just horrible…It was cold, it was just horrible. Then I just sat there one night and I'm sitting there thinking, "I don't know what to do." I'm like, "What am I doing because I have all this money and I have all these drugs and these drugs feel so good."
> **Q:** And were you spending most of your money on drugs?
> **A:** Yeah, that's mainly what my money went to. As soon as I'd come back with the money my boyfriend would take it. So I had no access to it. Not even five dollars of it. He used to take it so I had no money to myself.

Recommendation 44: That Manitoba Health recognize the central role of male partners in the lives of pregnant women with substance misuse problems, and that specific services to work with both the woman and her partner be developed to assist couples in developing more supportive and stable environments for themselves and their children.

Recommendation 45: That Manitoba Health promotes the development of better service links between addiction services and women's shelters.

d. Barriers Related to Socio-geographic Factors

Women reported several barriers in accessing addiction treatment that were related to their socio-geographic environment. These barriers stem from certain realities in specific geographic regions, such as shortages of housing in smaller urban and rural communities, or to other social responsibilities in a woman's life, such as employment or school responsibilities. Socio-geographic barriers included:

- limited choice of treatment programs which are accessible in or near the community where she lives;
- fear of losing housing if she entered a residential treatment program;
- difficulty placing personal belongings into storage due to lack of money, storage options, and/or help to move them;
- no services in her community that prepare consumers for treatment (i.e., information about programs);
- she was never referred or approached by service providers to enter addiction treatment;

cannot financially afford to take time off work to enter treatment; and

enrolled in school and cannot take time off to go to treatment.

Concerns about housing and storage of belongings were key considerations women thought about when deciding to attend residential treatment. Women interviewed in Thompson and The Pas were much more concerned about losing housing than women who were interviewed in Winnipeg. Because of housing shortages, women in smaller urban centres and rural communities preferred short-term residential treatment programs or outpatient/day programs where they did not have to give up their housing in order to enter treatment. The problem for women was not just that they had to move out of their homes, but they also had to find secure storage for their belongings, and a place to live after leaving treatment. These women also spoke about the problems women have in accessing services when they live in communities where there is limited or no public transportation. For example, one woman who was interviewed was planning on going to a treatment program in the near future but was concerned that she might have to give up the house that she and her children had lived in for several years. Three months later, she explained that she had decided not to go to treatment because she could not afford to pay the rent for the house while she was in the program. As she saw it, her options were to either give up the house or not go to treatment. Because she did not want to uproot her family and risk the chance of not finding another suitable house after completion of the program, she decided it was better if she did not go to treatment at that time.

The location of treatment services was also a concern for women. This was particularly true for women in rural communities. In most cases, these women were not offered treatment in their home communities but had to travel to a residential program. Arranging to go into treatment was difficult in these situations as very few service providers are located in these communities to assist women. Pregnant women in small communities were reluctant to go to treatment while pregnant and preferred to spend the duration of their pregnancy at home with their families. This was particularly true for young women, or women who had never been to a treatment program.

For service providers who work in smaller urban centres and rural communities, shortage of staff, the distance between communities, and under-funding have made it difficult for them to work with women who need addiction treatment. Added to this is the lack of confidentiality in small communities where everyone knows who is receiving help for substance misuse. This has meant that pregnant women have been reluctant to seek help not only because they are afraid the whole community will know, but also because CFS may find out and choose to intervene with regard to their children.

Service providers throughout the province reported that they do not have enough resources to provide the type of outreach services needed in the communities they serve. For example, in Thompson, service providers reported that pregnant women are sometimes taken into custody by the police under *The Intoxicated Person's Detention Act* and held for several hours. Because there is no agency in Thompson that provides services to women who are in this particular situation, these women typically leave the police station without any type of service referral. The problem for the police in this situation is that because the women are intoxicated when they are taken into custody, they cannot be taken to the women's shelter because the shelter has a zero tolerance policy on substance use. The Addictions Foundation of Manitoba treatment centre in Thompson is also not prepared to admit these women as the service they provide is for individuals who are committed to participate in a residential treatment program. In the AFM's experience, having the police bring intoxicated women to the centre for treatment simply does not work because the women are not prepared to be in a treatment program and will likely leave as soon as they can. Therefore, the problem for service providers in

Thompson is that they have identified that this group of pregnant women are falling through the gaps in service provision. However, there is no agency that has the ability, under current mandates, to address the service needs of these women.

Women also reported barriers related to other social responsibilities in their lives, such as employment and school, which prevented them from accessing addiction treatment. For example, women who are employed or attending school cannot always afford, financially or otherwise, to take time off work to attend a treatment program given their other responsibilities. Since most programs in Manitoba are either residential programs or programs that operate during the day, women who are employed or going to school either have to take leaves of absence, quit their jobs or courses, or seek help outside of treatment programs through self-help groups such as AA or NA. One woman explained:

> I want the help. I need the help but I can't. Not right now because I have someone to support. I have a job that I'm actually moving up and I don't want to jeopardize that. I don't want to ruin it.

e. Stigma

Stigma directed toward pregnant women who misuse substances was reported as contributing significantly to why many women felt they could not access addiction treatment. These included:

> fear of the stigma others will direct toward her or her family if she admits to needing treatment;
> fear that if she admits to having an addiction, she may not be promoted at work, or may lose her job;

The stigma and shame that society places on women with substance misuse problems, particularly pregnant women, is enormous. For the women who participated in this study, societal attitudes toward them did not go unnoticed. As one woman stated: "It is not just the fact that you're an alcoholic, it's that you're an alcoholic and pregnant. That's what makes society hate you." Because women who misuse substances while pregnant are part of the larger society, they too share and internalize the moral beliefs held by the general population. As increased medical and social attention is directed toward the problem of substance misuse during pregnancy, women who use substances while pregnant are increasingly condemned and stigmatized for their behaviour. During the course of this project, it was found that pregnant women who misuse substances are one of the most despised groups in Manitoba. This has resulted in women feeling guilt and shame about their substance use, and in many cases, causes them to isolate themselves from the services that could help them.

Women often turn to misusing substances as a way to cope with the guilt and shame they have internalized. For example, one woman explained how she felt after the birth of her baby:

> ...You know, she was sick all the time. Her low birth weight and her development was irregular, it was shifting. Anyway, so I felt as soon as I heard that she was diagnosed with FAS, just the guilt, God, it's my fault that my baby is sick because I drank and I didn't even know I was pregnant. I shouldn't have drank. I shouldn't have drank even after I knew that I was pregnant. And the cocaine, and the smoking up…So I felt really guilty. I guess I couldn't live with that guilt. She was still in the hospital and then my girlfriend and I went to see her and I started drinking. Because I didn't know how to deal with it. Who to talk to, where to go.
> **Q:** Did they offer you any support when they told you that your daughter had FAS?
> **A:** I was just dulled. I didn't know, I was too shy or too afraid to ask for help. Who do I talk to? I didn't know what kind of support was out there. Anyway, I didn't come in for a visit [to the hospital], I was out drinking…I guess that's when, because I didn't come in for a day or something like that when she was in intensive care, they ended up calling CFS and said that I had abandoned her at the hospital.
> **Q:** Which in your mind you hadn't done at all?
> **A:** No, no, I was out drinking but I was being irresponsible, right? And then the next day I went

> and found that she was in the custody of CFS. And so after that there was nothing I could do. I couldn't take her home…Somebody stole my baby away from me without me even knowing. I have to say in it, I have no rights. So when that happened, I just, boom, I left the hospital and that's when I really started drinking and I didn't stop. I kept drinking every day. Every day I would spend money or borrow money or whatever. I was getting money to drink or I'd be bumming off my friends to get drunk. That's it, I went right down.
> **Q:** What kind of support were you offered?
> **A:** Nothing.

Increased attention toward substance use and pregnancy in Manitoba has had an impact on the lives of women in all socio-economic groups. This study found that women from middle- and upper-income groups do not typically access addiction treatment programs which are funded by Manitoba Health. Rather, these women access addiction treatment through private therapists and clinics, or through treatment programs outside of the province. However, it should be noted that in all likelihood, many women from middle- and upper-income families are simply not accessing treatment anywhere because of the stigma attached to substance misuse by pregnant women. Data from this project suggest that certain groups of women, such as women from particular ethnic groups or women who are members of military families, may also be prevented from accessing addiction treatment because there are no socially-acceptable avenues for them to seek help. For example, a pregnant woman who misuses substances and is married to a man who is a military officer, has few, if any, socially-acceptable avenues to access addiction treatment because public knowledge of her problem would be seen to bring shame and embarrassment to her and her family.

The stigma associated with addiction to substances has also meant that some women feel that if they admit having a problem with substance misuse and want to enter treatment, they could face the possibility of losing their jobs or of not being promoted. While some employers encourage individuals with substance misuse problems to seek addiction treatment, there is still a great deal of stigma attached to women, particularly pregnant women, who want to take a leave from work to attend treatment. As well, women felt that once labeled as an "addict" or "alcoholic," they were less likely to have new employment or training opportunities offered to them.

Recommendation 46: That Manitoba Health create a public health campaigns that is designed to de-stigmatize pregnant women who abuse substances.

f. Treatment Program Barriers

Women interviewed for this project reported several barriers directly related to treatment programs that prevented them from accessing treatment. These included:

long waiting lists;
detoxification or withdrawal management services do not exist close to where the woman lives;
no detoxification or withdrawal management services for women-only;

wanting help for her addiction, but shuffled from service provider to service provider without ever receiving a referral to a treatment program;
had problems accessing information about treatment programs;
no transportation to outpatient treatment, which is especially difficult for pregnant women;
afraid to leave her community to go to treatment, but there are no programs available in her community that meet her needs;
none of the residential treatment centres that are close to where she lives address her particular needs as a woman;
residential treatment does not exist in or near her home community;
addiction counselor had to travel a great distance to reach her community, and therefore only came once a week, and some weeks was not able to come;
felt that the quality and integrity of the treatment program offered in her community was compromised because counselors who worked at the program were not healthy themselves;

could not attend addiction treatment because the program in her community is offered during the same hours as she works;
problem of confidentiality in smaller urban centres and rural communities, everyone knows who is in the treatment program;
some treatment centres will not take pregnant women who are in the last trimester of pregnancy;
there are too many rules to follow while in treatment;
the language used at the treatment centre she wants to attend is a language she does not understand or speak;
there are too many people in the treatment program that she does not want to encounter;
relapsed after two attempts at treatment in the only available program where she can take her children; no other treatment options are available to her;

required to do a six-week outpatient treatment program before entering residential treatment;
keeps dropping out of outpatient treatment because she is still living in the same social environment where everyone is using substances;
problem finding good one-on-one counselling for addiction;
most treatment programs require participation in group sessions and she does not want to participate in them;
limited choice of treatment philosophies among the treatment programs that she can access;
treatment programs are not designed to accommodate individuals with certain physical or mental disabilities;
does not want to attend treatment with men, but no treatment programs are available for women only that she can access; and
asked to leave treatment and cannot go back right away.

Consumers interviewed for this project identified numerous barriers related to treatment programs that prevented them from accessing addiction treatment services. The most common barrier reported was the waiting list for many treatment programs. Even though pregnant women have been prioritized for addiction treatment, women generally seek treatment at times when they are not pregnant. In many cases, women face waiting periods of anywhere from one week to several months for programs they want to attend. This is especially the case for programs specifically designed for women. Many women stated that long waiting lists meant that they did not have a choice as to the type of treatment program they could attend. Instead, they attended whatever treatment program was available at the time. This was particularly true for women who needed to access treatment in order to regain custody of their children. One woman explained her experience with long waiting lists:

> And you know what? I had my name on the list there. And by the time I'd been through all the treatment here, had my kids home and everything was fine, they phoned me. Like, I wanted to go and live in a treatment centre! I still think I need it. 'Cause my thinking is off. My way of living, my thinking is off. My self-esteem is toast. Everything is toast. Even though I'm a strong person. And I've wanted to go there so badly 'cause I wanted them to break that way and start me all over again. And like, I put my name in February and in August they phoned me. I could have been dead by then. I could have decided I didn't want treatment then. Thank God I had been through treatment. Like, I'm just, I'm not trying to make myself feel better but I was a lucky one. That's nuts.

Several women in the study reported that they did not access treatment because there were no treatment programs in the community where they were living. Some women also reported that lack of transportation to outpatient or day treatment programs prevented them from accessing treatment. This was particularly true for women who had to travel to a different community for treatment, for women who lived in cities where there was no public transportation, and for women who had pubic transportation but lived far away from where the treatment program was being offered. Many women in the study did not have cars or someone to drive them to treatment. Lack of transportation was also a factor in preventing women from attending treatment aftercare and self-help groups.

Lack of confidentiality was one of the most significant reasons women in small communities gave for not accessing treatment. These women were afraid that if they entered treatment, the whole community would know they were admitting to having an addiction. They believed this could jeopardize their jobs, cause problems with family members, or create the possibility that CFS would apprehend their children. For example, one woman explained how she felt about going to treatment in her home community:

> I thought about it and I just keep thinking, "What if I run into somebody I know and they know this person and that person knows that person?" That's a scary thought. I mean if it were me just walking into a faceless building where nobody knows that I'm there I could probably do it. And I'm going to be sitting with just one person and this person doesn't know anybody I know, for sure then I probably would go.

Women also reported that they did not go to treatment programs in their community because of the feeling they had about staff members of the program. This reason was given much more often by women in smaller urban and rural communities. Because treatment programs in small communities have a limited pool of people to draw upon when hiring counselors for their programs, they often end up hiring and training individuals from the community who have successfully completed their program. Several women reported that they did go to the local treatment program because some of the counselors were drug addicts or alcoholics. While women generally felt that counselors who had been addicts or alcoholics had an greater ability to identify with them and understand their struggle with substance misuse, this was usually the case only if the woman had not known that counselor while he or she was using. Women were suspicious of the quality and integrity of programs that employed counselors who only months previously were part of the local drug and alcohol scene. Some women simply did not want to open up and talk about their substance misuse problems to someone—particularly a man—whom they had partied with in the recent past.

Women reported that the current actions of treatment program staff members in their community played a significant role in how they felt about their local treatment program. For example, in one community, a local addiction worker was also the bouncer at a downtown bar. Some of the women felt very uncomfortable with this because they said it compromised their privacy and placed them under a type of informal surveillance. They felt that his employment at a local bar was in direct conflict with his role as an addiction counselor. Other women reported seeing local addiction counselors intoxicated in bars. The women felt that this type of behaviour by counselors brought into question the commitment of the counselor and the treatment program to providing quality treatment that was meaningful for clients. From the point of view of some women, if counselors were themselves abusing substances, then they were no different from the people who they were trying to treat.

A barrier that was reported by several women was that treatment programs do not make enough accommodation for persons with disabilities. Women with physical as well as learning disabilities reported barriers to treatment related directly to their disabilities. For example, most information about treatment programs and how to access them is in printed form, which can cause problems for people who are blind or have learning disabilities. Illiteracy was also a factor in the lives of a number of the women interviewed and contributed to women not being able to access information about treatment programs. Women with disabilities and women who were illiterate were also fearful that they would not be able to participate fully in a treatment program, and that they would be stigmatized by staff and other clients. In addition, for women with mental illnesses and substance misuse problems, accessing addiction treatment was very difficult because most treatment programs are not equipped to accept persons with such conditions. According to service providers, these women have greater difficulty accessing services and programs in general.

Some women who were interviewed reported that they were afraid to go to specific treatment programs because they knew that they would be asked to participate in activities that would make them feel uncomfortable. Examples of concerns that women raised are: being afraid to talk about themselves and sensitive issues (e.g., sexual and childhood abuse) during group sessions; being afraid that if they spoke about their substance misuse problems they would be judged by the other clients and staff because they were pregnant; and being uncomfortable with group sessions that included both men and women. In many cases, women gained their knowledge about treatment programs from friends and family and then based their decision to go or not go to a particular treatment program depending on what they were told. Other women reported that they did not access certain programs because they did not agree with the treatment philosophy of the program. Most of the women believed that there were not enough addiction treatment services specifically for women

Women identified a number of barriers related to treatment programs that prevented them from accessing addiction treatment services. While 66 of the 74 women experienced some type of barrier when accessing addiction treatment, 58 of those women did participate in an addiction program at some point in time. The following section will deal with the treatment experience of these women, the reason why some of the women did not complete treatment, and the experience of women in participating in aftercare programming.

3. The Treatment Experience

Of the 74 women who participated, 58 (78%) had attended addiction treatment These women were asked to discuss their positive and negative experiences while in treatment. Women who had been pregnant while in treatment were asked to discuss their particular experiences as a pregnant woman.

Among the women who attended treatment there were differing views on the value of particular treatment programs. The majority of women who entered treatment did so because they were coerced or forced into a program This study found that the reason why a woman enters addiction treatment directly affects what happens to her while she in the program. The reasons why she enters addiction treatment are generally as important an influence on her treatment experience as the treatment philosophy of the program. For example, some women were preoccupied throughout their treatment with proving to CFS that they were fit to either have their children with them in treatment, and/or that they were capable of parenting their children once they completed treatment. These women's concerns about the treatment program and its underlying philosophy was secondary to their concern about convincing CFS that they were capable parents. This was one of the main reasons why women wanted to access long-term treatment programs, as many had CFS workers who saw long-term treatment as a positive sign that they were serious about making changes in their lives. In other words, for many women, it simply did not matter what type of addiction treatment program they accessed as long as it filled the demand for addiction treatment that was required by CFS, or in some cases, social assistance. The result was that many women entered programs that they normally would not want to attend, they participated in activities that made them feel uncomfortable, and they remained preoccupied with finding ways to say and do all the right to convince CFS to either let them parent the baby they were expecting and/or to give them their children back.

It must be noted that women who participated in addiction treatment programs to fulfill a CFS, social assistance, or court-ordered requirement generally reported that they did benefit in some way from their treatment experience, including decreasing or ceasing to use for a period of time. For many women, treatment gave them a new perspective on their substance misuse, including a language in which to understand and discuss their use. However, one woman, who had a child diagnosed with FAS, pointed out that understanding addiction as an illness or a coping mechanism changes drastically in treatment programs when the woman is pregnant. Instead, she argued, it is viewed as a moral issue by service providers and by the woman herself. Rather than an open discussion and dialogue occurring in treatment programs, the issue of substance use and pregnancy is buried in shame and secrecy:

> It [substance use during pregnancy] is not talked about, there is a tremendous amount of secrecy. In my experience there has been a lot of secrecy about addiction and pregnancy in places like Alcoholics Anonymous and treatment services for women. Alcoholism is a disease and it's not a moral issue, and yet it really very much becomes a moral issue…when you drink and/or do drugs while pregnant. And because of all that secrecy you don't talk about it and if it's not even discussed in a place like Alcoholics Anonymous or a treatment centre the secrets get buried even more and even more. And I know in my experience it makes it very difficult to heal because my issues for myself—and I'm not speaking for all mothers—have always centred on my guilt and shame from drinking when pregnant.

a. Positive Aspects of Treatment Identified by Participants

long-term individual counselling services, particularly on an outpatient basis;
when pregnant, the treatment centre gave her food, milk and looked after her;
felt she was doing positive things for her unborn baby when she was in treatment;
her children went with her to treatment so she did not have to worry about them being in foster care;
program helped her to learn how to grieve for the loss of her children who were in the permanent custody of CFS;
learned more about what solvents could do to her and to her unborn baby;
the treatment program was only for women;
participating in women's groups, helpful to talk to other women;
learned about Aboriginal culture, participated in healing and sharing circles;
the environment of the program was very positive and supportive;
she was able to go to treatment with her partner;
the treatment program gave her time to focus on her sobriety;
the treatment centre was located outside of the city;
the treatment program was short-term;
she could stay in treatment long-term;
the work/training initiative gave her employment skills;
the work/training program increased her self-esteem;
the structure, schedule and daily routine of the program;
learned how to talk about her problems;
had a positive relationship with her addiction worker;
learned more about her addiction, came away with a better understanding of why she misused substances;
learned to live without alcohol;
liked being with other girls her own age who were going through similar problems with substance misuse;
learned that to change your life you have to want to;
program taught her how to get along with others;
AA meetings were held at the treatment centre;
she was comfortable in treatment because she was with other Aboriginal people;
treatment allowed her to get away from her social environment;
sharing and talking to other people in a positive environment;
the food at the treatment centre was very good, helped her to focus on feeling well and to deal with her addiction.

b. Negative Aspects of Treatment Identified by Participants

did not receive special consideration because she was pregnant, lack of support;
some staff and clients felt she used her pregnancy as an excuse to get out of work;
coerced by counselor to disclose to other clients, male and female, that she was pregnant and had been using;
felt that workers at the treatment centre stigmatized pregnant women who were in treatment;
she was pregnant while in treatment and had to leave the centre because she had completed the program, and she did not feel confident after she left that she could maintain abstinence;

wanted information about fetal alcohol syndrome but none of the workers would talk to her about it;
secrecy in treatment about addiction and pregnancy—none of the other women in treatment with her reported that they used substances while pregnant; they all said that they stopped while pregnant and therefore she felt that she was the only one; this greatly increased the guilt and shame she had about using while pregnant; counselors did not try to explore this topic with the group;
methadone program did not give clear information about methadone treatment and the risks associated with methadone treatment and pregnancy;
counselors treat addiction when a woman is pregnant differently than they do when the woman is not pregnant; it becomes a moral issue when she is pregnant rather than being seen as an illness or disease;
treatment centre does not have facilities so you can take your children with you;
CFS did not allow her to have her children with her in treatment as they had initially promised when she was told by them to go to addiction treatment;
her children were very stressed while they were with her at the program;
female clients have to work and look after their children while in treatment, not enough time to focus on their substance abuse problem;
worried about her children who were in foster care;
no preparation to be in treatment;
program did not address her needs as a woman;
treatment program had all male counselors;
she was the only woman in the treatment program; this was very difficult because she was also the youngest client and felt very uncomfortable with other people in the program;
there were only women in the treatment program; she preferred programs that had both men and women participating in them;
could not go to AA meetings while in the treatment centre;
the treatment program places too much emphasis on client participation in work tasks, such as kitchen duty and not enough emphasis on counselling and group sessions;
many of the male clients at the treatment centre were men who had been recently released from prison or jail;
program did not succeed in helping her with her addiction;
nothing in common with other clients in the program. Did not share same cultural and social values;
had problems understanding what she was being taught and the information she was given. Problems with reading and comprehending some of the discussions and information;
no special provisions for people with disabilities;
did not feel she belonged because she was so much younger than all the other clients in the program;
was seeing a private counselor for addiction treatment. He sexually abused her;
too many rules to follow while in the program;
loneliness;
program only deals with your addiction and not with other things such as past sexual abuse and relationship violence;
the treatment centre is located to close to old neighborhood where she did most of her using;
did not feel comfortable with the staff and other clients;
did not like being separated from partner;
lack of privacy;
felt that the work, such as kitchen duty, that she was expected to do at the treatment centre was punishment;
program equates all substances as being equally addictive and equally harmful. And, that if you are addicted to one substance than you are addicted to them all;
asked to leave treatment because she did not believe in a zero tolerance philosophy. She was not given a referral to another more appropriate program or service;
total abstinence is not for everyone, but she cannot find a treatment program that has a harm reduction philosophy;
forced by counselors to talk about past abuse

but did not want to;
nothing interesting or relevant in the program for youth;
treatment sessions include people with all types of addiction. Does not like being in treatment sessions with "sniffers;"
difficulties with roommates;
treatment program was not long enough; Cannot change years of a particular lifestyle in just one month;
the building that the treatment centre was housed in was very rundown;
problems with men who were in the program, felt threatened by them;
men in treatment were a distraction from dealing with substance misuse problem;
intimidated by men in the program. They had too much anger;
not enough attention to a holistic approach which takes into consideration the spiritual, emotional, physical, and psychological;
treatment program was too clinical. Information difficult to understand and counselors did not address issues that were meaningful to clients;
treatment centre located too close to the bar;
had problems discussing past sexual abuse when there were men in the group session;
program was too institutionalized;
detoxification centre was not clean, but it was the only option available to her;
returned to treatment after having dropped out and was given extra work duties as a punishment.

c. Program Environments and Attitudes

In the experience of women who participated in addiction treatment, very few programs had created environments where they felt safe and secure to talk about their use during pregnancy. One exception to this was the Laurel Centre, a women's program in Winnipeg, where long-term individual counselling occurs on an outpatient basis. Unfortunately, this program has a long-waiting list and is therefore inaccessible to most women.

Women reported that they were very reluctant to announce in group sessions that they had used substances while pregnant for fear that the treatment staff and/or clients would stigmatize them. However, in a couple of cases, pregnant women reported that they were forced by counselors to divulge to other clients that they were pregnant and that they had been using during their pregnancy. Women also reported that they were afraid that if they admitted to using substances while pregnant, their CFS worker would find out and later use this against them. As a result, most women reported that they kept this part of their substance abuse history a secret, and therefore did not have an avenue to deal with the guilt and shame they were feeling. Women who did admit in treatment that they misused substances during pregnancy reported feeling increased anxiety because they thought they were the only ones who were incapable of abstaining from substance use while pregnant. Women who had been in treatment longer were more likely to feel comfortable talking about sensitive issues in group sessions or with counselors.

Women reported that being pregnant while in addiction treatment influenced how other clients and staff treated them in other ways. For example, one woman explained the attitude of a staff member of a treatment program she had attended while pregnant:

> **Q:** Were there other pregnant women in the program?
> **A:** No, I was by myself.
> **Q:** And, did they [the treatment centre] know that you were pregnant?
> **A:** Oh, yeah. You could see.
> **Q:** Did you feel uncomfortable in the program because you were pregnant?
> **A:** This one lady, I was walking through the hallway leaving the program and there was this lady who is actually the receptionist there and she said in French as I walked by, "She should be ashamed of herself," not realizing that I speak French. I turned around and I told her, "No, you should be the one that's ashamed of yourself You're suppose to be helping us, not condemning us"...Oh, she nearly fell off her chair. The other lady that was there, she just looked at me and I looked at her and I said, "I'm going to report

> you." And I reported her but there's really nothing, like, she's still there when I go back for appointments. She just didn't look at me when I went by. Like, you don't have control.

Other women reported a lack of sensitivity to their pregnancies when it came to issues such as work responsibilities assigned as part of treatment. This was particularly true in larger centres where women had to deal with a greater number of people throughout the day. For example, one woman explained her experiences with men while in treatment:

> I felt really mad because sometimes I was in a lot of pain with him [her baby] and I hated to always have to ask if I could go rest. My worker said it was okay with her. But if I'd go and ask one of the men, the staff, you know, they wouldn't understand. They'd go, "Like why?" I'd say, "I'm in pain." They wouldn't understand. When I'd ask the worker, she's a woman, she'd go," Yeah, go right ahead." But with the men I'd have to give them an explanation.

A second woman recalled her experience:

> **Q:** And were you ever pregnant in any of these programs?
> **A:** The first time I was. I lasted a month in there.
> **Q:** Did you get extra consideration, like time off because you were pregnant?
> **A:** No, people always thought I used it as an excuse.
> **Q:** They didn't give you extra time off or anything?
> **A:** It doesn't matter. You don't get no special care.
> **Q:** And when you were in treatment did people treat you differently because you were pregnant?
> **A:** Some.
> **Q:** Better or worse?
> **A:** Worse.
> **Q:** In what way?
> **A:** I think the men were worse. If they can't carry something they try and make you carry it.
> **Q:** So they weren't helpful at all in this respect?
> **A:** No.

Not all women who were pregnant while in treatment had negative experiences with other clients and staff. For some women, treatment programs gave them needed support and security. Residential treatment programs allowed pregnant women to live outside of their normal social environment. This was why most women agreed that long-term programs were better for them when they were pregnant. As one woman explained:

> ...'Cause I just want to keep my baby this time. I don't want nothing to go wrong. But I'm really struggling too because I went to treatment. I was there in May. I finished in June, and then I came back [home]. I was doing okay for awhile and then I fell off again. So I started using again…It's, like, easier if you just stay in the program until as long as you can. See, I was thinking if I stayed in there through my whole pregnancy then it would have been a lot easier.
> **Q:** But the option to stay wasn't available to you?
> **A:** You got to go out a month, then come back or whatever. So I was going to go but my boyfriend didn't want me to go back.

One younger woman explained how she felt supported in the program she attended which was in contrast to the isolation and loneliness she had felt prior to coming into the program:

> **Q;** And so,…you said that there were positive things. What kind of things were these?
> **A;** In your spare time you could talk to the other girls. Go rent a movie with them, talk or just sit around and pig out with popcorn and chips.

Women who had been pregnant while in addiction treatment all agreed they felt they were doing something positive for the baby they were expecting. For some women, this positive feeling was enhanced by support they received from addiction counselors and from people in their social network who supported their participation in treatment. However, pregnant women in short-term treatment, generally finish treatment long before their pregnancies end. This means that they can lose valuable support at a crucial time in their lives, particularly if they do not have support mechanisms in place once they leave treatment. Even though most addiction programs offer aftercare services, many pregnant women, for various reasons, do not attend the programs, and most programs leave it up to the woman to make the effort to access the service.

d. Duration of Treatment Program

The duration of treatment programs was one of the key factors women spoke about. The problem women most often reported about short-term programs was the assumption that within 21 to 28 days a person could make meaningful gains in overcoming long-term substance abuse. For example, one woman explained how she felt when she had to leave the program:

> ...It was okay. It was too short. And they had no idea what to do with cocaine. And I'm just a dually-addicted, all-type-of-addicted kind of a person with a lot of pain from my past. You go in there [for treatment] and they just open this can of worms and then it's time to go. And I remember standing on that doorstep bawling that I'm not ready to go. I was crying, "I'm not ready to go."
> **Q:** And what did they say to you?
> **A:** Well I didn't tell them that. I was doing that to myself. I wasn't ready to go.
> **Q:** And did they give you options? Did they hook you up to other services?
> **A:** Well yeah, you know the meetings and after program. But that's not the same. Not when you've spent years on the streets and your whole life has been there. It's not like it was a weekend thing. It was a whole lifestyle kind of a change...I ended up going back anyway because I kept doing all the same things I was doing, drinking and using the drugs...
> **Q:** So then in terms of treatment programs, if you were to say what you feel is needed now what would the program look like?
> **A:** I think a long-term, one year [program] for me. And learning all these coping skills. I have no perseverance skills. That self-esteem. All those things...and it has to be in a living environment twenty-four-seven. For me....[the treatment counselor] said "Why do you need another treatment centre, you know what you need to do." I said, "I need positive everything, it just has to fill my life."
> **Q:** What do you think about a 30-day program and then coming back to your same environment?
> **A:** It's not enough. Then life just takes right over. Even now I have a lot of support and it's hard. I still think about fucking using.

Another woman similarly responded when asked if a short-term program was long enough:

> ...No, for Child and Family too. But I think too what's a month? What's two months? What's three months? Four months is getting a start I think. Maybe six months to a year.
> **Q:** And you would be willing to stay in a program that long?
> **A:** I need the time away.

A third woman explained that she thought her three-week stay in the local addiction treatment centre was not long enough. However, because she was able to go for aftercare she still felt connected to the treatment program and was able to make a fairly easy transition back to living in her home environment:

> ...I had just talked to them [her children] on the phone and I had occasional visits with them. And so I put my mind to it and I said, "Well, this is it, I can't take it anymore, my body can't take it anymore. One of these days I'm going to die and then who are they going to have?" So I made an appointment with [the treatment centre] and I went in there and I did my three weeks. And it was just like the sky was so blue, the birds were singing, it was just like a whole different meaning. But then it came to discharge day. It was just like, if felt like I was getting kicked out of my own home, the only place I felt safe. I said, "I don't want to go, I want to stay here. I feel safe and secure in this place. Because I don't know how it is out there after I've been in here."
> **Q:** And you were only there for three weeks right? So by the time three weeks were over you felt like you were just getting into things?
> **A:** Oh, yeah, and I felt so safe and secure but it didn't end there. I got, um, what do you call it?...? Is t outreach? That's when you go and see a counselor once a week or something?
> **Q:** Aftercare?
> **A:** Yeah, aftercare. Oh, I felt so relieved when I walked back into that place 'cause that's where I sobered up. That's where I made a difference in myself. And my boys were so much happier

e. Separation from Children

Women who had voluntarily placed children in foster care or had children living with friends or relatives while in residential treatment reported that they preferred short-term treatment programs. For these women, having to be apart from their children for more than three weeks or a month was simply not an option. This included pregnant women. If they could not access a program that allowed children to go with them, or an outpatient program that allowed them to live at home, then these women preferred short-term programs. The question of whether the treatment program could be successful in that short a period of time was secondary to the concerns they had about leaving their children in the care of someone else.

For similar reasons, women who were employed preferred short-term programs. In their situations, it was often the case that they could not stay away from work for more than three weeks or a month. Because many of these women did not want their employer to know that they were attending an addiction treatment program, they did not ask for time off to go to treatment. Instead, they either took holidays or a leave of absence. Women who were employed did not typically express the same type of insecurities about their addictions and returning to their home environments as did women on social assistance. This did not mean that employed women experienced fewer relapses, but rather that they reported having more positive support mechanisms in their lives, including their jobs, that made them feel more confident in returning home.

For a pregnant women, the preference for a particular treatment program is often directly connected to having a "birth alert" placed on her. Of the 16 pregnant women who participated in an addiction program, nine had entered treatment for this reason. Five of the remaining seven pregnant women reported being in treatment because their children had been apprehended. Both groups of pregnant women reported they were preoccupied with finding ways in which they could convince their CFS worker that they were capable of parenting their child(ren) while they were in treatment. In cases such as these, it was not unusual for the woman's addiction counselor to intervene on behalf of the woman to convince the CFS worker that she had taken positive steps in dealing with her addiction and was ready to parent some or all of her children. For example, one woman explained:

> I told her [the CFS worker] I was pregnant and then about a month later she said, "We're going to be taking away your baby." So I came here. And she was still saying that to me another month later. And then by the time I had three months here my worker had talked to her [the CFS worker's] supervisor and they decided to let me keep my baby because I was doing really well.

In many cases, pregnant women were successful in convincing CFS that they were capable of parenting their babies because they were in an addiction treatment program. However, this usually occurred only if the woman was in a long-term residential treatment program where she could remain until the birth of her baby, and return directly afterwards with her newborn to the treatment centre. In Manitoba, only a few residential treatment programs allow pregnant women to do this. Because most residential programs—including those specifically for women—are short-term or outpatient/day programs, they do not have the capacity to allow pregnant women to meet CFS requirements. This leaves pregnant women who have "birth alerts" placed on them with only one or two options for addiction treatment. It means that women are basing their choice of treatment programs not on what they feel will best help them with their substance misuse problem, but on what will best help them to convince CFS to let them parent their newborn babies.

Data from this project found that "birth alerts" were placed mostly on women who lived in Winnipeg, and therefore strategies by pregnant women to enter long-term residential treatment because of "birth alerts" were specific to this group. This was supported in interviews with women and service providers. Women in Manitoba generally do not go to an addiction treatment program when they are pregnant. This is specifically true for women who live outside of Winnipeg. For example, of the 16 women who reported attending an addiction treatment program while pregnant, only one woman lived outside of Winnipeg. Addiction service providers in smaller urban centres and rural communities reported that they seldom had pregnant women participating in their programs or asking for referrals to programs in other parts of the province.

f. Treatment Location

Several factors affected women's experiences while in treatment that were not directly part of the treatment counselling. Included were factors such as the geographic location of the treatment centre, the type of building it was housed in, the living arrangements while in treatment, and the woman's perceptions of other clients. For example, women interviewed in Thompson and The Pas who were not residents of these cities reported having few, or in some cases, no options for addiction treatment that were in or near their home communities. Many of these women did not want to travel to urban centres for treatment, especially if they were pregnant. Many of the women who traveled long distances to treatment reported feeling isolated and lonely, especially in the initial period. In general, women reported that they were less likely to go to a treatment program when pregnant if it was located far away from where they lived. This was supported by information given by addiction service providers who said they typically did not see pregnant women enter their programs from communities located in other regions of the province.

The type of building in which treatment programs were housed also influenced the experience of women. Women reported that treatment centres reminded them of other institutions they had been in such as residential schools, youth protection facilities, and jail. Other women reported that they enjoyed the communal living that residential treatment offered. This was particularly true for young women who reported enjoying the time they spent with other women their age. Some women spoke about how specific treatment programs were housed in buildings that were in need of repair. This was supported by interviews with some service providers from treatment programs who said that because of increased budget cuts they were just barely able to maintain their buildings and furnishings. For example, one woman explained her first impression of a treatment centre she attended:

> When I walked in, it took me three days to unpack though. Just because it looked like an old shabby run-down place. I said, "I have a nicer place at home than this." But it ended up being a pretty good place and I was grateful that there was a place. Had I not been there I probably would have used again.

g. Other Clients

Many women spoke about their experience s in treatment in reference to other clients. This was one of the most important variables contributing to a woman's experience while in either residential or outpatient/day programs. Data from this project suggest that among individuals who go to addiction treatment programs and among substance users in general, there is a type of informal social hierarchy. Typically, individuals who use inhalants are at the bottom of this hierarchy and are the group most stigmatized by other treatment participants. Illicit drugs, such as heroine and cocaine, are situated somewhere in the middle of the hierarchy, and alcohol is usually seen as the least stigmatized substance. This hierarchy of use stays the same for pregnant women, but marijuana is generally seen as less harmful to the fetus and therefore less stigmatizing than any of the other substances.

In discussinq treatment programs, women often reported that they were uncomfortable with other clients based on that person's substance of choice. Some women also felt that the service needs of clients should be based on the type of substance they misuse, rather than everyone being lumped together as "addicted." For example, one pregnant woman explained how she felt about other clients in a woman's treatment session she attended. In this example she describes in a very negative way the women who were in the program because of inhalant abuse. However she then goes on to explain that pregnant women—of which she is one—should not be put in the position where they are judged by other non-pregnant clients and staff:

> ...Yeah, I went there for a little while. It was just gross. I didn't want to be around these people. Some of them were really gross.
> **Q:** Do you mean the other clients?
> **A:** Yeah, they were just physically disgusting. Like, they didn't bathe. And I didn't see myself in that class because I just don't know why. I know every addiction is the same and you're in the same class but I couldn't stand sitting next to a sniffer. You can smell it. It's in their clothes. It's in their skin. It's disgusting. There was one girl there that made me very uncomfortable because she was severely deformed and I guess she had been born to a sniffer and she was a sniffer. And it's just that you look at that and you get weirded-out. You don't want to go back there. Why not just set up a program if you're addicted and you're pregnant? They should have one specific program to deal with these people. Okay, everybody's knocked up. Everybody's got an addiction. So this way nobody's judging, "Oh you're bad, oh, you're really bad. I'm better than you are because you're pregnant and you're doing it."

In another example, a woman discussed her experience at a detoxification program she attended to keep her room at a shelter. She explains that her problem with being in detox was not with the program itself, but with the other clients in the program:

> **Q:** What was it like being in detox?
> **A:** It was shitty. Well it wasn't really shitty but just the people I was staying with there. They're nothing but bums and rubbies. It was disgusting. It was very disgusting. But I didn't have a choice.

While not all women in the study reported such a negative reaction to other clients, these examples illustrate the types of social dynamics that can occur between clients in a treatment setting. This dynamic greatly influences the ways in which different individuals experience treatment, and whether or not they feel a particular program is a safe place in which they can find meaningful help for their substance misuse. These particular women felt uncomfortable and preoccupied in the program as they responded to the group dynamics. At some level, the other clients were likely feeling the same way. The concern is to question how social dynamics play out around the issue of pregnancy. Are pregnant women who use particular substances such as inhalants further stigmatized by staff and clients because of their substance of choice? Are women, particularly pregnant women, leaving detoxification and treatment programs early because they do not identify with the majority of the clients in the program, and feel that they are being judged and stigmatized? Data collected for this study, while limited, suggest that in both cases this is what is occurring. However, further information is needed to fully understand the situation.

h. Male Clients and Staff

Relationships between men and women in mixed treatment programs, particularly residential programs, affected women's treatment experiences significantly. In some cases, women were indifferent about whether men were in the same program as them or not. However, other women reported having difficulties being in treatment with male clients. One woman stated:

> Because you can get sidetracked. You can lose focus very easy. A man comes along... And you know what you're thinking about, "Am I too fat, am I pretty enough, is my hair nice?" All that are distractions that you don't need to think about when you're straightening out.

Four women reported having affairs with men either while they were in treatment together, or after they had completed the program. In one case, the affair ended while they were still in treatment and the woman left the program before completion.

Several other women expressed their discomfort with speaking about their substance misuse and issues related to their use such as relationship violence and sexual abuse in group sessions where men were participating. One woman explained her discomfort with mixed treatment groups:

> Actually, it did bother me for a while with men together. I don't know why, but maybe it's

> because, um, you don't want to talk about the things that happened when you were a child. You don't want to share things with the men. I feel more comfortable sharing it with women. That's one suggestion I wanted to make one time when I came in here. Like, why can't they just um put the women together and separate the men and the women.

Several women reported that they had been afraid and intimidated by some of the male clients who were in treatment programs with them. For example, one woman said that she preferred treatment programs that were only for women as men expressed too much anger and rage during group sessions. Other women reported being in treatment with men that they had past involvement with outside of treatment which made them feel uncomfortable, and at times, unsafe. Two women reported being in a residential treatment program where they were the only women in the program. In one case, the woman was very young and said that she felt she had nothing in common with the older male clients. In both cases, the women were expected to participate fully in the program on the assumption that being the only woman in the program would have no impact upon their treatment experience.

Some women reported that they did not feel comfortable with male counselors. In three cases, women reported inappropriate sexual advances by male counselors while they were in a residential treatment program. In another case, a woman who was seeing a private therapist for her substance misuse ended up being sexually abused by the counselor. Other women felt uncomfortable with hugging and affectionate touching by male counselors because they were not sure whether these gestures were simply gestures of support and reassurance, or if the counselor had a different, more sexual, motivation.

KEY RECOMMENDATION 47: That Manitoba Health, in conjunction with a wide range of service providers and addiction treatment programs, ensure that women at risk of misusing substances while pregnant feel safe and secure in accessing services that are meaningful to them and best support them in reducing or ceasing to use substances. Strategies should include:

a. providing a range of addiction treatment options to women;
b. ensuring services mandated to assist women in accessing addiction services educate them about available treatment options to enable them to be informed consumers;
c. requiring addiction treatment programs targeting women to develop services that are sensitive to issues of gender, drawing on proven gender-specific addiction programming currently available in Manitoba and other parts of North America;
d. requiring addiction treatment programs to include an evaluation component to determine their effectiveness and value to women participating in them;
e. making safe and accessible child care services available to women near to where they attend treatment; and
f. removing long waiting lists as a barrier that prevents women for accessing the treatment program they prefer.

A few of the women who were interviewed attended treatment with their male partners, and in some cases, whole families were living in treatment centres. Generally, the women reported that going to treatment as a couple or as a family was much better than one person in the relationship seeking treatment while the other remained outside and continued to abuse substances. Being in treatment together meant that the couple could support one another during the program and focus on the treatment, rather than worrying what the other one was doing while they were apart. It meant that the couple could support and encourage one another when they returned home after completion of the program. While attending treatment with a male partner may not necessarily always work out in such a positive manner, for the women, the treatment experience became more meaningful because they had their partners with them.

i. Privacy

Women also reported that the lack of privacy in residential treatment programs was at times very difficult. For example, when asked to explain why she preferred outpatient programs, one woman contrasted her experience in outpatient programs with her experience in residential treatment:

> **Q:** What was it like going to an outpatient day program?
> **A:** It was fine. At least I had some privacy. I didn't have no weirdo I didn't know staying with me in my room…I think they should have rooms that are private and you have your own single space so you don't have some other, excuse the pun, junkie staring at you shaking, making you feel worse…And imagine being stuck in a room with a complete stranger crying every minute of the day because she wants her drug. How depressing can that be? Or they sit there and talk about the drugs…there are girls [in the treatment centre] doing drugs. This girl offered me a freakin' mickey. How did she get a mickey in there? Like, don't they check these people to make sure they don't have anything?

Other women reported being robbed by roommates while in treatment, and being afraid of some of the other female clients.

j. Treatment Philosophy

The majority of women reported that treatment strategies aimed specifically at the needs of women were the most beneficial and positive approaches to addiction treatment. However, in their experiences, not all programs with services specifically for women were successful. In many cases, women felt that programs specifically for women were basically the same treatment strategies generally used minus the inclusion of men. Attention to issues that were specific to women were not necessarily dealt within these programs, including the issue of substance use and pregnancy.

Women had differing views about the type of treatment philosophy which best suited their needs. For some women, a program that took a harm reduction approach best addressed their needs, while for others, a zero tolerance or complete abstinence model worked best for them. In many cases, differing models worked or did not work for the same woman at different times in her life. For example, one woman discussed how she had been involved with a program that took a harm reduction approach and had done very well over time in decreasing her substance use. However, she felt that in order to be happy in her life she needed to quit using substances completely. For this, she looked to a long-term treatment program in which abstinence was required.

Some women reported that certain treatment programs were too clinical, and spent too much time explaining addiction in technical language that was both confusing and boring. Other women felt that certain programs did not focus enough on a person's addiction and spent too much time on developing life skills. Some women disagreed with the amount of work they had to do in certain programs that was outside of treatment sessions and unrelated to addiction counselling. On the other hand, many women felt that work initiatives were way to build self-esteem and gain valuable skills for when they returned to their home environment.

For women who participate in methadone treatment, it helps to stabilize their use by providing them with daily prescriptions of methadone. In this way, they are no longer putting themselves at risk by using street drugs. However, for women who are pregnant, methadone treatment raises several unsettling contradictions. First, what are the health risks caused by methadone treatment during pregnancy? Second, is methadone treatment understood by CFS as a treatment program for substance abuse that can cause harm to the fetus or "unborn child?" Would CFS place a "birth alert" on a pregnant woman who is participating in a methadone program? Would CFS eventually apprehend her newborn baby? Third, what are the health risks of ceasing methadone treatment during pregnancy and what are the other treatment alternatives?

Several women felt that some treatment programs treated all substances as equally harmful and addictive. The treatment philosophy of these programs views any substance as part of an addiction. Other women saw their substance use as an addiction to one or two main substances, but not to other "less harmful" substances. This was particularly true with regard to marijuana use, and in some cases, the use of alcohol. This is not to say that these women disagreed with treatment programs that took the stance that addiction is more than just a physiological addiction to a substance, but that they felt these other, "less harmful" substances were not part of their "addiction" problems. The contradiction for many women was that they would enter a program because they had a problem with a particular substance, but the program treated them as if they were addicted to all substances.

> ...I wanted to go into an addiction program...I went through their whole program and then one day before graduation they discharged me because I said I would smoke pot in the future and I was in there trying to get off cocaine. So I need to go back and try to do it again because I didn't like them to begin with. And they won't take me [back], they just told me to do an outpatient program. So they weren't very helpful....I was being honest with them, that yes, I would probably smoke pot in the future. And they said, "We don't see no reason for you completing this program. You're going to have to leave." And I had done the whole program except one day.
> **Q:** And there was nothing you could do about that?
> **A:** I was pretty upset. So I used as soon as I got out of the course. Because I was upset about it...I felt that it was hard work going through it and I got nothing out of it. Well, I did get something out of it if I thought about it more. At the time I was upset about getting kicked out.

The treatment experience for women is as diverse and varied as the experience of addiction. However, to understand the treatment experience further, it is necessary to look at the reason why women do not complete addiction programs they enter.

4. Dropping Out of Treatment

Among the 58 women who had been to an addiction treatment program, 18 (31%) reported they had either dropped out or were asked to leave a program. The women gave several reasons this happened, many of which mirrored the reasons why women did not enter treatment in the first place.

TABL3E 21: PARTICIPANTS WHO LEFT ADDICTION TREATMENT EARLY	Number	Percentage
Winnipeg (N=36)	13	37%
Thompson (N=9)	3	33%
The Pas (N=13)	2	15%
Total (N=58)	**18**	**31%**

a. Reasons for Leaving Treatment

The following reasons for leaving treatment early were given by women who participated in the project:

feelings of helplessness and hopelessness because she was not with her children;

needed to drink to cope with life, no purpose in life, no direction in life;

did not feel comfortable in the program;

left treatment because CFS did not allow her children to be returned to her while in treatment as they had promised;

spouse was not in treatment, left because he wanted her to come home;

was not prepared for treatment, and could not cope with the program;

did not like the philosophy of the program;

still using, and was not ready to be in treatment;

had a secret affair with a male client that ended while in treatment. Could not cope with being in treatment with him after the affair ended;

treatment centre located in old neighborhood and it was too easy to start using again;

men were using same showers and bathroom, felt very uncomfortable;

could not complete outpatient program when living in environment where there was a lot of substance use around her;

was afraid to lose her housing, left to return home to keep housing;

not comfortable with mixed treatment and having to talk about difficult issues such as past sexual abuse in front of male clients and/or counselors;

pressured to answer questions in group sessions

that she did not want to answer;
felt treatment was not helping her and she could do it just as well on her own;
found out boyfriend cheated on her and so she left treatment;
lied to counselor that she was using so that they would ask her to leave because she wanted to go home. Felt lonesome for family;
young and not ready to quit using;
anxiety attack;
problems with boyfriend;
decided she did not need treatment because she was not as bad as the other clients were;
asked to leave program on the last day because she admitted that she might use again;
asked to leave program because she was using;
asked to leave program because she was being aggressive toward other clients;

b. Social Environments

The reasons women do not complete addiction programs they enter are varied. Some reasons are based on circumstance external to the program and are related to a woman's social environment. These can include issues concerning her partner and children, or issues related to her home and community. For example, one woman talked about why she left a program that she was doing very well in:

> ...I did three weeks, I had one week to go.
> **Q:** And what happened?
> **A:** I should have completed. I didn't relapse at that time I just, um, I was just trying to look after my place because somebody asked me if they could live there until they found a place and I didn't want any parties there. And I didn't want to get kicked out 'cause I don't want any problems with housing.
> **Q:** And so you felt it was better to go home and look after your house?
> **A:** Yeah.

Another woman discussed why she dropped out of treatment because she could not break away from influences in her neighborhood:

> It used to be just, like, a 30-day program, you could get in right away but now it's different, now you got to do a six-week outpatient program before you can even get in there. You see, I was gonna try that and I only lasted two days…where it's located that's right in my district. It's like my hotel where I hang out, it's two blocks away. And all my friends are there. Like, that's the North End, that's where I was brought up.

c. Treatment Programs

For other women, factors related to the treatment centre influenced their decision to leave the program. Many times this happens in the very early stages of the program before the woman feels comfortable with the treatment environment. This is particularly true for residential clients. One woman discussed why she left a treatment program that she had wanted to go to:

> My mom and dad tried to put me in an addiction program…They took me out there and I stayed one night…I always wanted to check it out but that night I went there it was alright. But the morning when I got up, I was going to take a shower and all these guys are walking in the shower while I was there. Walking into the washroom while I was taking a shower! So, like, that's not right.

Another woman discussed her feelings about why she left a residential program:

> **Q:** And what happened around the circumstances when you left? Did you decide to leave?
> **A:** I decided to leave 'cause it was kind of a strict place.
> **Q:** And so what were the things about it being strict that you didn't like?
> **A:** The rules and that. You had to sit on the seat if you were bad in the hallway. You had to be careful about your kids.

In some circumstances, women leave treatment and try other programs that work better for their particular situations. For example, one woman explained how she eventually ended up in a treatment program with her partner:

> The reason why I went out there was that when I found out I was pregnant I was drinking pretty heavy and I just didn't want that happening anymore. So I went to the Chemical Withdrawal [Unit] and started from there. And then I went to AFM and I was in AFM and, um, I took off from there because I phoned my boyfriend or he

> phoned me…and he told me he had cheated on me. So that really hurt and so I took off from treatment and I ran all the way. Well, I took the bus and went to my mom's and then right away I started drinking. I grabbed that vodka and I just downed it. Then I felt hurt after…He goes, "I don't want you drinking with this baby"…and I said, "If you don't want me drinking with the baby why are you cheating on me?" I said, "Let's go to treatment together." So that's the choice we made, we went together. And everything worked out good over there.

Another woman explained how she dropped out of treatment at two different residential centres before finding one that worked for her:

> ...I was with my kids and I knew I had an alcohol problem. I was trying to get help…so I called CFS and I asked them to help me. And then they said, "Okay, you go to these treatment programs." I said, "I'm going to try St. Norbert," and I tried there for 24 hours and I didn't make it so after that I tried Peguis. I was there for like two days. And then from there I went to Sagkeeng and then I made it.
> **Q:** And what do you think is the difference between what didn't work and what worked was?
> **A:** I have no idea. Probably because of maybe the rules or something. I don't know.
> **Q:** Was it the people or maybe the atmosphere?
> **A:** Both.

Other women who leave treatment early are asked to do so by the program. Most often, women refer to this as a failure on their part—that they were "kicked out" of the program. In other cases, they blame the workers or other clients. For example, one woman explained the circumstances around her being asked to leave a treatment program:

> I got into an argument with a girl. And I don't know, I let my temper get to me more than anything. I showed them what I'm all about. Like, I can get very angry and they didn't like that. And once you show violence then you're gone. And twice I did that. I got into an argument with the girls. And because they got frightened of me, I don't know how. But that's their excuses so they dismissed me.

In cases where women are asked to leave a program there is generally no follow-up by the program. Many women feel devastated by this event and usually begin using heavily right away. As these women tend to have very low self-esteem, being "kicked out" or "dismissed" from a program is experienced as failure even if they do not agree with the reasons for which they were asked to leave. In some cases, being asked to leave a program early means that the woman never tries to access treatment again based on this experience.

5. Maintaining Recovery

Maintaining recovery, whether a person has been in treatment or not, is a difficult challenge for the majority of individuals who have problems with substance misuse. For many of the women who participated in this project, maintaining recovery was interrupted with periods of substance use. In other cases, women were able to cease using the substance which they identified as being a problem for them—such as crack cocaine—but continued to use other substances like marijuana, which they felt did not present any problem for them. These women reported fewer or no periods of relapse as compared to women who saw relapse as the use of any substance.

a. Reasons for Relapse

not enough aftercare services;
loneliness;
not ready to quit using;
all her friends were using around her;
depressed about being on welfare and living in poverty;
twenty-eight day program was not long enough;
isolation and/or boredom;
children in the care of CFS, helped her to grieve for the loss she was feeling;
could not cope with the emotional and psychological pain she was feeling;
thought she could handle her drinking because she had stopped for so long;
partner came back into her life and he was using;
no support;
she had nothing else in her life but alcohol;

had to use in order to be able to work the streets;
frustrated with CFS, trying to get her children back but they kept breaking their word about returning them;
fear her children would be apprehended by CFS;
lived over a hotel that had a bar;
stress in marriage;
stopped going to support meetings;
sponsor from support group made a pass at her;
relationship problems with partner;
guilt and shame that she had used while she was pregnant;
a way to cope with her partner rejecting her;
moved back to old neighborhood;
started using again after she was raped;
children apprehended by CFS, started using right after;
stress, too many problems in her life to deal with.

b. Aftercare Services

One of the main reasons women gave for relapse was insufficient aftercare services once they returned to their home environments. This was supported by service providers who also cited compounding issues of poverty, unemployment, poor housing, violent neighborhoods, and mass substance abuse in the social environments in which their clients lived. Addiction service providers also pointed out that relapse was part the recovery process, and should not be seen as a failure or as abnormal. In most cases, particularly with individuals who have been abusing substances for many years, relapse will occur.

When women were asked about aftercare services and what they felt worked, they typically referred to a number of different support factors in their lives. For example, one woman was receiving support from Villa Rosa, a residential pregnancy home she had stayed in during and after her pregnancy. She attended AA meetings, individual counselling at the Laurel Centre, had a good relationship with her family, had custody of her child, had a circle of friends who did not use substances, and was in a relationship with a man who was very supportive of her. This woman explained that even though she had a great deal of support in her life, and was motivated to access that support to maintain her sobriety, there were still times when she felt drawn back to using substances. In most cases, women did not have this type of support in their lives. For various reasons, they were unable to access aftercare support from service providers.

One of the biggest barriers to aftercare was geographical location. Women who lived outside of Winnipeg, particularly in small, remote communities, left residential treatment and returned home to communities where there was no aftercare. Sometimes, because they were not close to the treatment centre they had attended, they could not take advantage of the aftercare services offered by that centre. In some cases, the treatment centre linked women to services that were available in their communities, but in many cases, women did not feel comfortable accessing those services (i.e., reasons of confidentiality, afraid CFS would find out). Other barriers that prevented women from accessing aftercare included:

no child care services available;
too busy dealing with other things that were happening her life, such as caring for children, working, coping with poverty, etc.;
partner not involved in the aftercare that is offered;
no transportation to meetings;
depressed, does not want to leave her house;
fear that children will be apprehended;
aftercare only offered once a week, and often conflicts with her other responsibilities.

Most women who relapsed had a period of abstinence following their treatment. In this period, they attempted to apply what they had learned in treatment to their everyday lives outside of treatment. In many ways, this worked better for women who had been successful in completing outpatient/day treatment programs because they were already living at home. For women returning from residential treatment, making the transition often was not easy, as they found themselves back in the same circumstances as when they left for treatment. For example, one woman explained what happened to her after she completed treatment:

> **Q:** What happened after you came out of the program?
> **A:** Well actually, I quit for awhile but then I had friends coming around, like old friends and stuff and that's how I started again.
> **Q:** Did you go to their aftercare at all?
> **A:** I didn't keep up with it. I was too busy all the time. Like, I had my daughter back with me and I was too busy with CFS and everything.

Recommendation 48: That Manitoba Health ensure that adequate aftercare services are in place for pregnant women returning from residential addiction treatment, particularly in communities where there is widespread substance abuse.

KEY RECOMMENDATION 49: That Manitoba Health, in conjunction with addiction and outreach service providers, improve aftercare services available to women, including fostering increased communication among service providers, and effective follow-up services to connect women with positive supports in their home communities.

c. Pressure from Family and Friends

Pressure from family and friends who were using was a reason given by most women for relapse. Many women, including pregnant women, found that after returning home from residential treatment they were the only person in their families or circles of friends who was not using. While they had a great deal of positive reinforcement from workers and other clients in the treatment program, once they returned home, that positive support was often replaced by negative responses from families and friends such as indifference, anger, or resentment toward the woman's effort and accomplishments in treatment. Women spoke about returning home to see their families and friends, only to find that nothing had changed. One woman explained:

> It was long enough [the treatment program] for me because I didn't want to be away from my kids. But as far as helping, it helped when I was there but as soon as I got off the bus back in town I went right back to the same house where everything happened. My same neighbors, same friends. Like, I don't really have that many friends but it seems everybody here is into one sort of addiction or another. I think there should be follow-ups. Like I said, I put myself in there so it's probably just up to me to follow myself up.

d. Returning to the Community

A second reason given by many women for relapse was because they returned to lives of poverty and an overwhelming amount of anxiety about how to cope without substance use. Compounding the issue of poverty, were other problems such as dealing with isolation, loneliness, and boredom. A large number of women were also dealing with CFS in attempts to get their children back. These were very difficult periods for women, and some reported that reunification with children was not easy, especially if they had been apart from their children for long periods. Women reported feeling overwhelmed with juggling everything in circumstances where they had little support and few resources.

The ways in which women did maintained periods of abstinence were through various avenues such as attending AA meetings, going to sharing circles, seeing a private counselor, being involved in the "STOP FAS" program, going to family centres, going to school, going to outreach centres, taking children to the Aboriginal Head Start Program and attending church. Once again, barriers such as lack of child care and transportation problems made it difficult or impossible for women to access these resources.

6. Aboriginal Women and Addiction Treatment

TABLE 22: ABORIGINAL PARTICIPANTS	Winnipeg	Thompson	The Pas	Total
First Nation off-reserve	19 (46%)	9 (50%)	7 (47%)	35 (47%)

First Nation on-reserve	0	5 (28%)	2 (13%)	**7 (9%)**
First Nation non-status	4 (10%)	2 (11%)	0	**6 (8%)**
Métis	2 (5%)	1 (5.5%)	1 (7%)	**4 (6%)**
Non-Aboriginal	16 (39%)	1 (5.5%)	5 (33%)	**22 (30%)**
Total	**41**	**18**	**15**	**74**

One of the goals of this study was to look at the specific needs of Aboriginal women in Manitoba. This study did not look at addiction treatment services in First Nation communities. Aboriginal women who participated were either First Nation women living or accessing services off-reserve, non-status or Métis. Aboriginal women made up the majority of the women interviewed (70%).

For many Aboriginal women, meaningful addiction treatment included, or was based on, traditional Aboriginal teachings taught by an Aboriginal person. For other women, having the treatment centre located on Aboriginal land also made their treatment more meaningful. However, for some Aboriginal women, particularly women who were adopted and/or had grown up off-reserve, attending a program that they knew would be based on Aboriginal beliefs initially made them anxious. Even though they identified as being Aboriginal and wanted to learn more about this aspect of their identity, many did not know, for example, an Aboriginal language, ceremonies or teachings. They did not have the experience of growing up or living in a reserve or Métis community. As a result, they felt inadequate among other Aboriginal people who they were afraid would not accept them. At times, these feelings prevented certain women from entering a particular Aboriginal treatment program. In most cases, once they did enter treatment and started to feel comfortable in the program, learning about their Aboriginal heritage greatly enhanced their treatment experiences. One woman explained:

> Out in Edmonton, that was excellent. Like, that started introducing me to the native culture. And I had no clue about it whatsoever. I didn't realize what I was missing or what I had been robbed of, or you know, neglected…I'm starting to feel, maybe a little bit inside more, like an inch of pride, I guess. Not ashamed to be, not as ashamed as I was before to be called a native. You know. So I guess there's a lot of healing there.

Some Aboriginal women reported that even though they identified as Aboriginals, it did not matter whether the treatment program they participated in was based on Aboriginal philosophies and teachings. Other women identified more with their Nation (Cree, Métis) than with a pan-Aboriginal identity, and wanted to access services accordingly. For example, Métis women explained that their experience, as Aboriginal women was different from women who were from First Nation communities. The problem, they stated, was that they were generally lumped together with First Nation women and treatment programs and related services reflected the beliefs and practices of those nations and not that of Métis people. This was supported by interviews with Métis service providers who felt they were in constant struggle to provide services specific to the needs of their communities.

Barriers that Aboriginal service providers faced in providing services to pregnant women with substance misuse problems related mainly to geographical location, the long history Aboriginal women have had with CFS agencies, high rates of substance misuse in some Aboriginal communities, and the large number of Aboriginal women who are living in poverty. Cultural factors that distinguish the addiction service needs of Aboriginal women have, in many ways, been addressed because Aboriginal groups have been at the forefront in designing culturally-appropriate addiction services for a number of years. However, as with other addiction services, this does not necessarily mean that these programs are gender-sensitive, a critique given by some Aboriginal women.

Geographic location is very important when considering the needs of pregnant Aboriginal women. While Aboriginal women live in all parts of Manitoba, a large number live in isolated rural communities which makes service delivery particularly difficult. Some of these communities also have high rates of substance misuse linked to chronic poverty, unemployment, and historical circumstances. Removing pregnant women from these communities and sending them to treatment is difficult because the women do not want to leave their communities. Non-status and Métis communities usually do not have addiction treatment workers who live locally and provide counselling, so these women often have limited service options available to them in their home communities. Aftercare is a problem in remote communities because the lack of follow-up services contributes significantly to women relapsing after they return from treatment.

Aboriginal women were more likely to have children in the care of CFS than non-Aboriginal women. Custody orders were more likely to be permanent orders as opposed to temporary orders (where the possibility existed that a woman's children could be returned to her care). The history of large numbers of Aboriginal children being apprehended by CFS has contributed to Aboriginal women being reluctant to seek addiction treatment for fear that CFS will find out. It has also meant that this group of women has experienced personal loss, with substance misuse becoming an avenue to grieve for the loss of children they know they will never have a chance to parent, or in some cases, ever see again. Many Aboriginal women, through the process of child apprehension, have come to believe that they are "bad mothers," and have internalized guilt and shame about their "failures" to parent.

Many Aboriginal women lived in family and social environments where there were excessive amounts of substance abuse. This was usually compounded by other factors such as chronic poverty. Even though the large majority of women lived under the poverty line, Aboriginal women were the poorest of the poor. This poverty is directly related to historical circumstances that led to Aboriginal people losing their lands and their socio-economic base. For these women, this was particularly devastating because they mainly came from Aboriginal groups that had limited political leverage with the federal and provincial governments (i.e., Métis and non-status women) and were therefore that much more invisible.

7. Participants' Treatment Recommendations

The women who participated in the project gave several recommendations for addiction treatment services. These included:

a better connection between treatment services and the reality of women's lives;
assistance in helping women prepare to enter treatment (help with arranging to store; belongings, information about the treatment program and what can be expected, etc.);
long-term treatment that takes a holistic approach;
more relapse prevention and aftercare services;
more cultural sensitivity in treatment, including positive cultural supports in the program;
increased individual counselling;
more programs specifically for women;
inclusion of children in programming;
a clinic for pregnant women at the treatment centre;
more female Aboriginal workers;
more local support for women who complete treatment;
mechanisms to ensure that the workers who provide services are healthy themselves;

- more drop-in centres for prevention and relapse prevention support, especially small communities;
- access to treatment in the community in which one lives;
- more holistic programs and outreach services that are confidential and non-judgmental;
- more addiction services aimed at middle-class women;
- women-centred treatment that de-stigmatizes pregnancy and substance misuse;
- more support for women in methadone programs;
- a place for pregnant women to go to that offers all the services related to her pregnancy;
- treatment centres for families;
- detoxification services specifically for women;
- services that bridge mental health issues and addiction services;
- more support in the environment where the woman lives;
- increased hours of operation for outreach programs for women;
- special treatment programs for pregnant women;
- shorter waiting periods to get into treatment;
- better ways to find out about what treatment options are available;
- more outpatient programs;
- counselling for children as part of the treatment the mother is receiving;
- better communication between addiction treatment services and CFS;
- day care services for outpatient programs.

The following recommendations for services were given by a group of women who participated in a focus group session in Winnipeg:

- a year-round, 24-hour facility for pregnant women who want to stop using which would admit a woman, intoxicated or not;
- more involvement by women in the design, implementation, and evaluation of services to meet their needs;
- treatment programs that allow children to remain with their mothers;
- more individual counselling for sexual abuse and addiction;
- services that have a long-term commitment to the women they serve;
- no "birth alerts," which remove choices from women;
- experienced service providers who understand the reality of women's lives;
- more grassroots workers and services;
- more Aboriginal service providers;
- outreach centres that women can access anytime of the day or night;
- healthy service providers;
- mandatory admission to treatment (meaning that the government can ensure that women are admitted to treatment when they want to enter), and provision of outreach services and early education about treatment programs;
- a re-examination of CFS agencies and the power they have over women; CFS workers should be bound to the agreements they make with women, and contracts should be signed between the woman and her worker);
- harm reduction treatment programs;
- long-term treatment for six months to a year;
- ways to prevent women from losing their housing if they go into treatment;
- positive, supportive aftercare services which are easy to access;
- employment training;
- counselling services that help women who are leaving the streets;
- more transitional housing;
- treatment services for women, that acknowledges women as mothers and addresses their needs as mothers;
- more support for women who have babies (cribs, child care);
- women who are caring for their children but do not have legal custody should be given the same CFS benefits as women who have custody of their children;
- more programs for youth-support services, prevention education;
- when women are in the hospital after giving birth to deliver babies, they should be given a list of resources and helped to access them it they want;
- more mentor programs;
- services that address the linkages between poverty and addiction;
- consistency in the public health message.

PART 4:
CONCLUSION

This study found that the service needs of pregnant women who struggle with problems of substance misuse will not fully be addressed by any single service or program. In the view of women and service providers interviewed for this project, a collaborative effort among service providers is needed. Women overwhelmingly reported that the most valuable asset a service can offer is a supportive and non-judgmental environment where they feel free to work with service providers to address their needs.

This study also found that women were very pragmatic when accessing services. However, at times their pragmatism was misread by some service providers as non-compliance or indifference when women did not choose to access available services. For women, pragmatic approaches to service provision stemmed from various responsibilities, demands, past experiences and compounding circumstances that made up the daily realities of their lives. When making decisions about what services to access, women based their decisions within this larger context. This was supported by many service providers who felt their service mandates were at times too narrowly defined and inflexible, given the fact that their clients did not access services as fragmented individuals but were simultaneously dealing with various life issues.

At times, women were indifferent to the various avenues of service that could help them address their substance abuse problems. This was particularly true for women who were abusing substances heavily. In these cases, it was not uncommon for women to report that they simply did not see their life circumstances improving because things were too bad to get better. While pregnant women who abuse substances heavily are at highest risk of causing harm to the health of their fetuses, they are also at highest risk for substance abuse related illnesses. Therefore, it was a goal of this project to draw attention to substance misuse during pregnancy as a health concern related to the fetus, but also to the health of women.

Pregnancy, for high-risk women, is typically a time when they become increasingly visible to service providers and a time when they are able to access programs that will help to improve their health and well-being, and, in turn, that of their fetuses. This study found that it is also a time when women can be motivated by service providers to seek addiction services. Data from this study suggest that centres that provide gender-sensitive outreach services are in key positions to offer frontline counseling and support to high-risk women. They are also in a key position to work with other service providers, such as CFS, mentor programs, addiction services and pregnancy programs, to refer women to appropriate and meaningful services. Expanded outreach services have the potential to support and work with women while they are living in their home environments, and provide addiction aftercare services and relapse prevention in communities where this is currently not available. Outreach services also have the potential for building a sense of community for women who feel isolated and have limited healthy support networks. These services can also facilitate building community wellness, and promote support and encouragement for pregnant women to abstain from using substances within their communities.

Women in this study viewed excessive substance misuse during pregnancy as placing the health of their fetuses at risk and as problematic behaviour. However, compounding factors, such as mental health problems, relationship problems, and poverty often prevented women from addressing their substance misuse in their home environment. For some women, particularly pregnant women at highest risk of abusing substances, residential addiction treatment that takes them out of their home environment is often necessary as it provides an opportunity for them to benefit from treatment and to examine their options for the future, including how they will parent the child they are expecting. Pregnant women without children in their care agreed that long-term residential treatment for the duration of their pregnancy was their best treatment option. For pregnant women who had children in their care, concerns about child care were prioritized over other considerations when accessing treatment. This suggests that women need to have addiction services available to them that take this factor into consideration. According to women in this study, this can be accomplished by treatment programs making accommodations for their children, or for safe and accessible child care being provided. In cases where CFS is involved, clear understandings of what is expected of women having their children being returned to their care, or concerning a "birth alert," needs also to be agreed upon by the woman and her CFS worker.

Women and service providers in this study reported a number of barriers that prevent women from accessing addiction services. These were related to six areas: psychological barriers; barriers related to a woman's children; barriers related to social support networks; barriers related to socio-geographic factors; barriers related to stigma; and barriers related to treatment programs themselves. When reporting barriers to addiction treatment, women had differing views on what they considered a factor that prevented them from accessing treatment. As well, women reported differing experiences in treatment programs. However, treatment programs that offered specific programming for women, and individual counseling were viewed as the most positive by women interviewed. Differing experiences in accessing and participating in treatment suggests a need for individualized long-term treatment strategies to be developed with women and service providers that they trust, and should address the various barriers that exist. Treatment strategies should be developed within a framework that is sensitive to issues of gender, cultural, and geographic location.

To meet the service needs of pregnant women with problems of substance misuse, increased communication and flexibility among various service agencies is needed, particularly with regard to addiction service providers, CFS agencies, and health care providers. Services providers must also work toward a stronger continuity of care for women. As well, an open and non-judgmental public health message is needed which helps to de-stigmatize this issue for pregnant women, therefore allowing them to seek out the services they need without fear of judgment.

APPENDIX A: LIST OF RECOMMENDATIONS

Recommendation 1: That Manitoba Health develop a standardized "guideline of risk" for service providers who counsel pregnant women concerning risk and prenatal substance exposure.

Recommendation 2: That Manitoba Health ensure that prevention strategies that target school-aged children and adolescents include ongoing evaluation of their effectiveness.

Recommendation 3: That Manitoba Health ensure that prevention education directed toward adolescent girls includes information about accessing gender-sensitive youth treatment programs that address pregnancy and addiction as a treatment concern.

Recommendation 4: That Manitoba Health advocate that prevention programming directed toward women, particularly adolescent girls, be sensitive to issues of gender and the complexities of the problem which the prevention initiative is designed to address.

Recommendation 5: That Manitoba Health advocate that prevention strategies directed toward women, particularly adolescent girls, simultaneously address substance misuse and family planning.

Recommendation 6: That Manitoba Health advocate for a re-evaluation of the use of the "Baby Think It Over" doll in prevention programming directed toward adolescent girls.

Recommendation 7: That Manitoba Health ensure that public health posters and health education and information materials include information about where and how services, particularly addiction services, can be accessed by pregnant women.

KEY RECOMMENDATION 8: That Manitoba Health support the creation of mentor programs similar to the "STOP FAS" program for high-risk women in regions of the province outside Winnipeg, and mentor programs which address other substance addictions, particularly the use of inhalants.

Recommendation 9: That Manitoba Health support strategies that promote community wellness through outreach programs in communities with widespread substance abuse, and that these strategies include ways in which pregnant women can be supported and encouraged to abstain from substance use.

Recommendation 10: That Manitoba Health assist pregnancy outreach programs and residential homes for pregnant women to develop specialized services for pregnant women with problems of substance misuse, including counselling about service options for dealing with substance misuse, referral to addiction services, and aftercare support once a pregnant woman has completed treatment.

Recommendation 11: That Manitoba Health assist residential homes for pregnant women in providing, or in helping women to find, child care services that are safe and accessible during the period of their stay at the home.

Recommendation 12: That Manitoba Health support organizations that provide community services to pregnant women to improve communication and flexibility among such organizations, addiction treatment programs and CFS, so that pregnant women receive comprehensive information about available services that best fit their needs.

KEY RECOMMENDATION 13: That Manitoba Health develop the service capacity of gender-sensitive outreach services that women strongly identify as being supportive and trustworthy, particularly those services that deal with specific high-risk populations and in communities with widespread substance abuse. It is further recommended that these services work in conjunction with other agencies, such as addiction treatment programs and Child and Family Services agencies to support women in building healthy support networks, and decreasing or ceasing their use of substances before, during and after pregnancy, creating stable home environments, and expanding their education and employment options.

Recommendation 14: That Manitoba Health recognize the need for, and the benefit to be gained from, services that operate as places rather than locations for the delivery of a defined program. In particular, attention should be paid to the ability of this type of service to support women at high risk for substance misuse during pregnancy in building positive supports that will help them to reduce or cease using substances before, during and after their pregnancies.

Recommendation 15: That Manitoba Health support ways in which the hours of operation for outreach centres can be increased to include evenings and weekends, and increasing the number of staff and the amount of funding available to provide appropriate services and programming for the extended hours.

Recommendation 16: That Manitoba Health recognize that health care providers are in a key position to identify pregnant women who are at risk for abusing substances, particularly women who are less visible to other services providers. It is further recommended that health care providers be required to refer pregnant women who are misusing substances to appropriate services, and to follow-up with the women in subsequent appointments.

Recommendation 17: That Manitoba Health support the key role of public health nurses to provide support services to pregnant women who misuse substances, particularly in high-risk geographical areas.

Recommendation 18: That Manitoba Health support the hiring of more public health nurses of Aboriginal descent to work in high-risk areas where Aboriginal women comprise a large portion of the client population.

Recommendation 19: That Manitoba Health explore ways in which midwives could work as frontline service providers for pregnant women with substance abuse problems.

KEY RECOMMENDATION 20: That Manitoba Health recognize that Aboriginal agencies, such as Métis Child and Family Services, Friendship Centres, and the Aboriginal Health and Wellness Centre in Winnipeg are in key positions to work directly with high-risk pregnant women and communities which they serve under their current mandates, and are in the best position to create meaningful programs and services for Aboriginal women and to work with Aboriginal off- and on-reserve addiction services.

Recommendation 21: That Manitoba Health, in conjunction with CFS, encourage the hiring and training of more Aboriginal social workers to work with high-risk pregnant women.

KEY RECOMMENDATION 22: That Manitoba Health develop services for pregnant women who present for services when intoxicated, including women who are detained by police under *The Intoxicated Persons Detention Act*.

Recommendation 23: That Manitoba Health ensure that hospitals throughout the province work closely with addiction service providers to ensure that easily-accessible detoxification and withdrawal services are available to women in as many regions of Manitoba as possible.

Recommendation 24: That Manitoba Health ensure that detoxification and withdrawal services are sensitive to the specific needs of women, particularly pregnant women, and that these services assist pregnant women in finding appropriate addiction services upon discharge from detoxification units.

Recommendation 25: That Manitoba Health, in conjunction with service providers, find ways to help women develop strong support networks to rely upon during pregnancy, including more outreach and drop-in centres for women, programming directed toward family and community wellness, and recognition of high-risk situations, such as the apprehension of children that may place pregnant women at increased risk for substance misuse.

Recommendation 26: That Manitoba Health assist programs for women with long waiting lists by finding ways to meet service demands, including expanded services in current locations or multiple sites, increased trained staff, and financial resources for appropriate outreach and aftercare services.

Recommendation 27: That Manitoba Health increase the number of outpatient/day programs offered to women, particularly in areas of the province where it is difficult for pregnant women to access addiction services.

Recommendation 28: That Manitoba Health, in conjunction with addiction service providers, find ways to make accessing addiction treatment programs as confidential as possible for women, particularly pregnant women.

Recommendation 29: That when considering the budgetary needs of addiction programs, Manitoba Health recognize that funds for child care and transportation services are essential in removing the barriers women face when accessing treatment.

Recommendation 30: That Manitoba Health, in conjunction with addiction treatment services, educate a wide range of service providers about the realities of struggling with an addiction and the difficulties pregnant women can face when trying to reduce or stop using substances.

Recommendation 31: That Manitoba Health recognize that poverty and related factors play a central role in why some women misuse substances during pregnancy, and that services directed toward women need to address ways in which women can be meaningfully supported to improve their everyday life circumstances. These include, but are not limited to, improving access to education and employment opportunities, and ensuring that women and their children are safe and secure in their homes, neighbourhoods and communities.

Recommendation 32: That Manitoba Health recognize that women in all socio-economic groups are at risk of misusing substances while pregnant, and consider conducting further research specifically targeting middle- and upper-income women to determine the extent of substance use during pregnancy among this group and ways in which these women deal with their substance misuse.

Recommendation 33: That Manitoba Health support programming aimed directly at women under the age of 25 that takes into consideration the contributing factors, such as peer pressure and perceptions of risk, typical to that group.

Recommendation 34: That Manitoba Health recognize the importance of inter-generational substance abuse—even when children are in foster care and not living with their biological parents—as a risk factor for substance misuse and addiction, and develop programs and services which address the substance misuse of parents and grandparents of pregnant women who misuse substances.

Recommendation 35: That Manitoba Health, in conjunction with CFS agencies, find ways to decrease the number of foster placements a child may experience, and provide support services for transitional periods, such as movement between foster placements or movement of older adolescents out of foster care, to assist in healthy adjustments.

Recommendation 36: That Manitoba Health, in conjunction with CFS agencies, support the placement of Aboriginal children with Aboriginal foster families when at all possible, and when this is not possible, that foster families of Aboriginal children have knowledge of Aboriginal support services, and promote a strong, positive sense of Aboriginal identity for the children they foster.

Recommendation 37: That Manitoba Health recognize the link between mental health problems and substance misuse, and in conjunction with mental health agencies and addiction services, find ways in which gaps in service provision for women who struggle simultaneously with mental illness and substance misuse can be addressed. Within this framework special attention should be paid to the interplay of pregnancy, mental illness and substance misuse.

Recommendation 38: That Manitoba Health provide avenues for women with substance misuse problems to access individual counseling for issues such as past sexual, physical, and emotional abuse, suicidal thoughts, chronic depression, and other mental illnesses.

Recommendation 39: That Manitoba Health, in conjunction with women-centred health programs, such as the Women's Health Clinic, ensure that women have access to abortion counseling and services in all parts of the province, and that women have meaningful options if they do not want to have an abortion but feel they are ill-equipped to have a baby at that particular time.

Recommendation 40: That Manitoba Health recognize the central role that alcohol plays among women who misuse substances, and continue to focus on this central role in prevention and intervention programming.

Recommendation 41: That Manitoba Health create a public health campaign that specifically identifies binge use of substances during pregnancy as a health risk to a woman and her fetus.

KEY RECOMMENDATION 42: Recognizing the central role of Child and Family Services agencies in the lives of women with substance abuse problems whose children have been apprehended or will be apprehended at birth, that Manitoba Health, work collaboratively with CFS and addiction treatment programs, to find ways in which support services and treatment programs can provide meaningful service options for women when an apprehension order has been made. These service options should include:

a. intensive, supportive and non-judgmental support services, including grief counselling and referral to treatment programs, for women directly following apprehension of their children;
b. preparation for women to enter addiction treatment programs to ensure that they will gain the greatest benefit from the program;
c. formal written agreements between CFS and women as to the requirements which must be met in order for a woman's children to be returned to her care, or for an apprehension order to be lifted;
d. regular visitation schedules for women and their children during the periods of apprehension; and
e. the development of support services for women and their children once addiction treatment is completed and children are returned to the care of the mother.
f. training for CFS workers in addiction prevention and treatment.

Recommendation 43: That Manitoba Health ensure that women who enter residential treatment have safe and accessible child care services provided on site or near to where the woman is receiving treatment in order for the women to feel secure about the safety and care of their children, and to allow the parent/child relationship to continue while mothers are in treatment.

Recommendation 44: That Manitoba Health recognize the central role of male partners in the lives of pregnant women with substance misuse problems, and that specific services to work with both the woman and her partner be developed to assist couples in developing more supportive and stable environments for themselves and their children.

Recommendation 45: That Manitoba Health promotes the development of better service links between addiction services and women's shelters.

Recommendation 46: That Manitoba Health create a public health campaigns that is designed to de-stigmatize pregnant women who abuse substances.

KEY RECOMMENDATION 47: That Manitoba Health, in conjunction with a wide range of service providers and addiction treatment programs, ensure that women at risk of misusing substances while pregnant feel safe and secure in accessing services that are meaningful to them and best support them in reducing or ceasing to use substances. Strategies should include:

a. providing a range of addiction treatment options to women;
b. ensuring services mandated to assist women in accessing addiction services educate them about available treatment options to enable them to be informed consumers;
c. requiring addiction treatment programs targeting women to develop services that are sensitive to issues of gender, drawing on proven gender-specific addiction programming currently available in Manitoba and other parts of North America;
d. requiring addiction treatment programs to include an evaluation component to determine their effectiveness and value to women participating in them;
e. making safe and accessible child care services available to women near to where they attend treatment; and
f. removing long waiting lists as a barrier that prevents women for accessing the treatment program they prefer.

Recommendation 48: That Manitoba Health ensure that adequate aftercare services are in place for pregnant women returning from residential addiction treatment, particularly in communities where there is widespread substance abuse.

KEY RECOMMENDATION 49: That Manitoba Health, in conjunction with addiction and outreach service providers, improve aftercare services available to women, including fostering increased communication among service providers, and effective follow-up services to connect women with positive supports in their home communities.

APPENDIX B: CONSENT FORM (KEY INFORMANT INTERVIEW)

I understand that I am being asked to participate in an interview about my experience with the issue of substance abuse during pregnancy. I will take part in the interview under the following conditions:

1. The researcher has my permission to tape record and/or take notes during the interview; however, I can stop participating at any time. I can also ask that certain pieces of information not be recorded.

2. The tape recordings, notes and transcripts of the interview, and consent forms and other information will be the property of the researcher, Caroline L. Tait, for use in producing a final report to the Prairie Women's Health Centre of Excellence and Manitoba Health. My identity will be kept strictly confidential.

3. I have the choice of reviewing the summary of the transcripts of the interview. At this time, any new or relevant information can be added or changed.

4. I understand that the researcher will use the information collected from the interview to complete a report for the Prairie Women's Health Centre of Excellence and Manitoba Health, for presentations and/or scholarly publications, and to prepare recommendations for programming and policy which is aimed toward pregnant women with problems of addiction.

5. I can contact the researcher, Caroline L. Tait, at the Prairie Women's Health Centre of Excellence with any concerns or to withdraw from the project at any time.

Date:		
Signature of Participant:		
Signature of Researcher:		
Review of Summary Transcripts:	Yes	No
Comments:		

APPENDIX C: SERVICE PROVIDER QUESTIONNAIRE GUIDELINES

1. Please forward this questionnaire to the person or persons in your organization who provide services to women of childbearing age, specifically pregnant women. Feel free to copy this questionnaire and distribute it to those in charge of different programs and/or services.

2. When filling out the questionnaire please feel free to answer the questions using your computer. Match each answer with the question number that you are responding to. Please use as much extra space as you need. For questions which require a " " mark please use the form provided. Include both your questionnaire and those answers complete on separate paper when returning your questionnaire.

3. Not all questions will apply to all organizations. Only answer those questions which directly apply to your organization.

4. Add any other information that you feel is important in question 29, or on a separate piece of paper.

5. Please send any other relevant information about your programs and services, such as information pamphlets, risk assessment tools, service and program descriptions, evaluation tools, etc.

6. If you know of other agencies, organizations or community workers who you feel would make a contribution to the project, please feel free to photocopy the questionnaire or put them in touch with the project so that a questionnaire can be mailed to them.

7. This questionnaire is not an evaluation tool to evaluate your service(s), rather it is designed to let you, the service providers, explain where you are experiencing success with providing services to pregnant women, as well as where you may be running into difficulties. We also recognize that this group of women may represent a very small percentage of a service's clientele and therefore we do not expect all service provides will have, or should have, separate programs for pregnant women. Rather, we are interested in knowing more about the reality of providing services to this group o women from the collective perspective of service providers.

8. Please give information that applies directly to your organization's experience of providing services to pregnant women that access your program(s). If you do not see pregnant women in your program but can accommodate pregnant women within your service mandate please indicate this, however it is not necessary for you to fill out the questionnaire in this case.

9. Any information given in this questionnaire is the property of the researcher, Caroline L. Tait, Manitoba Health and the Prairie Women's Health Centre of Excellence will not see any of the individual questionnaires, not will individual service providers be identifiable in the final report written by the researcher. Individual questionnaires will remain strictly private and confidential. A report representing the collective experience of service providers will be written for Manitoba Health and the Prairie Women's Health Centre of Excellence.

10. The estimated time for completion of this questionnaire is about forty-five minutes.

11. Please return questionnaires by October 15, 1999 to:

Prairie Women's Health Centre of Excellence
Attention: Caroline Tait
Administrative Centre, University of Winnipeg
Room 2C1A, 515 Portage Avenue

Winnipeg, MB
R3B 2E9

APPENDIX D: SERVICE PROVIDER QUESTIONNAIRE

1. Name of your organization or agency.
   Contact person.
   Mailing address.
   Telephone: Fax: E-mail:

2. What type of service(s) does your organization, agency, or department provide (e.g., addiction treatment, outreach services, etc.)?

3. What consumer groups does your agency target? (check all applicable boxes)
   Women and men
   Women
   Families/women and their children
   Pregnant women
   Aboriginal [state nation(s) if you provide services to a specific nation(s)]
   Specific ethnic group(s) [state name of group(s)]
   Specific age group (state group)
   Rural population - north
   Rural population - south
   Urban population - north
   Urban population - south
   Reserve - south
   Reserve - north
   Off-reserve Aboriginal - north
   Off-reserve Aboriginal - south
   A single community
   More than one community (state number)

4. Approximately how many pregnant women does your organization provide service(s) to in a six-moth period?

5. What percentage does this represent of your total client population?

6. What strategies does your organization use to provide services to pregnant women concerning substance use during pregnancy (check all those applicable, including those under a general woman or client service that would include pregnant women)?

   Providing information about addiction treatment for women
   Providing information about addiction treatment for those with addiction problems that are involved in the pregnant woman's life (e.g., partners, family members, friends, etc.)
   Providing referral to addiction treatment for women
   Providing referral to addiction treatment for those with addiction problems that are directly involved in the pregnant woman's life (e.g., partners, family members, friends, etc.)
   Priority program entry for pregnant women
   Providing addiction counselling
   Providing addiction treatment aftercare
   Outreach to pregnant women who are not seeking service but are experiencing addiction

problems

Building trusting relationships with women in order to discuss substance use/abuse and pregnancy
Promoting prenatal health care
Promoting healthy prenatal nutrition
Providing written information on prenatal substance use
Providing education on substance use and pregnancy (individual or group education)
Identifying at-risk women for substance abuse/addiction
Identifying at-risk families for substance abuse/addiction
Identifying at-risk communities for substance abuse/addiction
Providing information about birth control
Providing access to birth control
Referral t other community services
Advocacy for the client with other service agencies
Advocacy for the client with her personal support network (family, partner, friends, etc.)
Facilitating access to child care
Transportation t appointments
Accompaniment to appointments
Visits to the homes of pregnant women
Parent/family support programs
On-site physician (at least once a week)
On-site nurse (at least once a week)
Other (please specify)

7. Does your agency have a specific program(s) aimed toward pregnant women with addiction problems? check one) Yes No

If your answer is No, do not answer this question, go to question 8.

(a) List the name(s) of the program(s) and the services provided by these programs (e.g., outreach, addiction treatment, day care, counselling, etc.). Attach any program description information you think might be helpful.

(b) Does the program(s) that your agency offers follow a specific model or philosophy (e.g., harm reduction, teachings of the Medicine Wheel, holistic approach)? Yes No
Please attach any relevant information.

(c) What are the risk assessment tool(s) that your program uses to identify women/families/communities who are at risk of having babies who are affected by alcohol/drug/chemical exposure in utero? Give the name(s) and a brief description. please attach any relevant information.

8. Within your current program structure do you provide services (e.g., counselling, referral, outreach) within more general programming (e.g., addiction programs, nutrition programs, Headstart programs) for pregnant women who ah=ve addiction problems? Yes No

(a) List the name(s) of the program(s) and the service offered by them (outreach, day care, counselling). Please attach any relevant information.

(b) Does the program(s) that your agency offers follow a specific model or philosophy (e.g., harm reduction, teachings of the Medicine Wheel, holistic approach)? Yes No
Please attach any relevant information and use extra paper if necessary to complete your answer.

(c) What are the risk assessment tool(s) that your program uses to identify women/families/communities who are at risk of having babies who are affected by alcohol/drug/chemical exposure in utero? Give the name(s) and a brief description. please attach any relevant information.

9. Do you offer specialized services to address pregnancy and the use of any of the following substances? check those applicable)

Alcohol
Cocaine and other stimulants
Heroin
Cannabis
Inhalants
Hallucinogens
Other (please specify)

10. In what ways do you involve fathers, partners, families or friends in any of the services aimed at preventing substance use during pregnancy?

11. Please indicate how your organization works with others to provide services to pregnant women with addiction problems (check appropriate boxes).

(a) Referral of pregnant women to other agencies
Often Occasionally Never
(b) Pregnant women are referred to your organization by other agencies
Often Occasionally Never
(c) Holding joint client consultations with other agencies
Often Occasionally Never
(d) Inter-agency exchange of program information and services
Often Occasionally Never
(e) Collaboration with health care providers (e.g., nurses, physicians, traditional healers, paraprofessionals, community health representatives, etc.)
Often Occasionally Never

12. What do you feel are the most successful components of service delivery by your organization when providing services to pregnant women with addiction problems?

13. What, if any, are the barriers that exist for your agency in providing services for pregnant women with addiction problems? (check all applicable boxes and give an explanation of the problem; add any other barriers on separate paper)

Identifying "high risk" women
Insufficient inter-agency communication and coordination (e.g., difficulties with referrals to, or from, other agencies; lack of knowledge or information about programs that are offered for

pregnant women, etc.)

Lack of adequate and secure program funding for you to give sufficient support to pregnant women specifically
Your organization needs more outreach, social, addiction, and/or community workers to adequately address the complexity and demands of service provision for women with addiction problems
Other

14. What are the service links, both formal (e.g., treatment referral, fostering of children) and informal, that you as a service provider have with other service providers or agencies that address the needs of pregnant women with addiction problems?

15. Do these service links break down? (check one)
Often Occasionally Never

If service links break down, in your experience as a service provider when and why does this happen?

16. What is the entrance and/or participation criteria required by clients who access the addiction treatment program offered by your organization? (e.g., a period of sobriety prior to entry; clients are admitted only as part of a cohort; the client cannot have certain medical [e.g., pregnancy] and/or psychiatric problems; once in the program the client cannot have contact with certain individuals such as family members, friends, etc.) Please attach any relevant information.

17. In your experience as a service provider which of the following, if any, do you feel are the barriers that prevent [pregnant women fro seeking and obtaining treatment for addictions? (check applicable boxes and give an explanation)

Issues of confidentiality
Insufficient support for the women (e.g., insufficient emotional support from family and/or friends; insufficient financial support to pay for rent etc. while they are in treatment; insufficient support from social, outreach and community workers)
Women are reluctant to seek addiction treatment because they are afraid the baby they are carrying will be taken from them when it is born and/or they will lose custody of their children if they admit to having an addiction problem
Women do not want to enter addiction programs that are located far from where they live
Women do not have the proper identification cards, such as medical or Status cards, which are required by treatment programs
Women are not sufficiently aware of the potential harms caused by alcohol/drug/chemical substances to them and/or the unborn child they carry
Other

18. Within the framework of the services you offer to pregnant women with addiction problems what are the target outcomes that these services aim for?

19. What types of support services does you organization offer to women who have completed addiction treatment? (E.g., support groups, counselling service, aftercare treatment)

20. Approximately hat percentage of pregnant women who enter your treatment program complete the program?

21. As a service provider what do you think are the main reasons why a pregnant women is, or is not, successful in completing her treatment program?

22. When pregnant women drop out of treatment before completion, what avenues, if any, do you have to reconnect with these women?

23. Approximately what percentage of pregnant clients to you estimate begin to use substances again after completing addiction treatment?

24. As a service provider, what do you think are the reasons why these women experience relapses? (E.g., there are no support services when the women return to their communities; previous loss of children to social services; social and economic marginalization)
25. As a service provider what services (either existing or new) would you like o see developed or enhanced to help you better support pregnant women with addiction problems?

26. Does your organization receive any special funding to provide services to pregnant women?
Yes No

27. Does your organization receive any special funding to provide services to women with addictions problems? Yes No

28. Does your addiction treatment program give entrance priority to pregnant women?
Yes No
If your answer is Yes, on average what is the length of time between the request for treatment and when she begins her treatment? If there is a delay, explain what factors contribute to this delay.

29. Please add any other comments or suggestions that you may have.

Thank you for your participation!

If you have questions regarding the Service Provider Questionnaire or the project in general please call Caroline Tait at (204) 786-9789 or e-mail: ctait@uwinnipeg.ca.

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